

Prevalence, Profiles and Policy

*A case study of drug use in
north inner city Dublin*



Isis Research Group
Centre for Women's
Studies, T.C.D.



ENTERPRISE
IRELAND

Prevalence, Profiles and Policy

**A case study of drug use in north inner city
Dublin**

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FOREWARD

Since their inception, both the Inter-Agency Drugs Project (IADP) and the North Inner City Drugs Task Force (NICDTF) have tried to ensure that their deliberations are influenced by accurate research and informed debate. Indeed, that approach has been a guiding principle of both organisations and, hopefully, will continue to be so in the years ahead.

Of course such an approach doesn't make for an easy life since many of us like to cling to our pre-conceived notions particularly regarding the whole issue of drug use which is fraught with controversy anyway.

However, despite these difficulties, both the IADP and the NICDTF feel that if we are serious about producing rational, humane and workable policies and programmes we have no choice but to base them on accurate information and reliable research.

Over the years, therefore, the IADP and the NICDTF have produced or commissioned various reports and evaluations in order to enable us to do just that. We have also tried to stimulate a broad debate on the various issues raised, not just in the north inner city, but nationally and globally.

Some of us in the IADP & NICDTF have not always agreed with the conclusions or recommendations in these various documents, indeed sometimes there has been some disagreement. However, we have always felt that it is better to stimulate debate and discussion around contentious issues in an open and honest way rather than to shy away from any controversy that might ensue.

It is against this background that I welcome the production of the ISIS report "Prevalence, Profile and Policy". The report raises a number of important issues and signals clearly, yet again, the need for integrated policies and resources, and creative and innovative ways of dealing with the drugs issue.

I would like to thank Jo Murphy Lawless, Emer Coveney and Sheila Sheridan, the authors of the report, and everyone who assisted them from local services and local communities. I look forward to this report making a positive and lively contribution to the ongoing debate and process around dealing effectively with problem drug use in the north inner city and beyond.

Fergus McCabe.

Chairperson IADP/NICDTF. June '99.

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Finally, we want to thank most sincerely all the people we interviewed and all those who participated in the quantitative data collection. We hope that the report findings and recommendations go some considerable way to changing their circumstances for the better.

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The views expressed in the book are those of the authors, and do not necessarily reflect the views of Enterprise Ireland or of the Combat Poverty Agency.

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Table of Contents

ACKNOWLEDGEMENTS	
PREFACE	1
SUMMARY	1
1 BACKGROUND TO THE PROJECT	5
1.1 Origins	5
1.2 Initial Scoping Work	6
1.3 Problems with the Present System of Data Collection	7
1.4 Setting Up Data Collection with the Agencies	8
1.5 Agency Observations on Patterns of Drug Use	8
1.6 Available Data Sources and Problems of Confidentiality	10
2 THE PREVALENCE SURVEY	11
2.1 Designing and Piloting Data Collection Sheets	11
2.2 Problems Encountered Carrying Out the Survey	12
2.3 Survey Results: An Overview of Main Data Findings	12
2.4 Patterns of Use within the Treatment Agencies	20
2.5 Multiple Service Users and Waiting Lists	22
2.6 Data from the Residents' Street Survey	24
2.7 Summary of Data Findings from Prevalence Survey	25
3 PROFILES	28
3.1 Introduction	28
3.2 Socio-Economic Characteristics from Questionnaire Data	28
3.3 Context of Group Interviews	32
3.4 First Involvements	33
3.5 Early Regular Use	35
3.6 The Social Settings of Heroin Use	36
3.7 Supply Issues and Supporting a Habit	40
3.8 Heroin Good and Bad	43
3.9 When Heroin Use Becomes Problematic	45
3.10 Seeking Treatment	47
3.11 Methadone and Stabilisation	51
3.12 Finding the Right Programme	51
3.13 Treatment Needs	52
3.14 Prevention	53
3.15 Summary of Data Findings from Group Interviews.	55
4 CASE STUDIES OF TWO USERS	57
4.1 Introduction	57
4.2 Case Study 1: Emily	57
4.3 Case Study 2: Billy	62
4.4 Summary of Points from the Case Studies	68
5 RESEARCH AND POLICY PERSPECTIVES ON THE HEROIN PROBLEM	70
5.1 Heroin - Its History and Current Economic Impact	70
5.2 Recent Qualitative Studies on Heroin Use	72
5.3 Policy Responses in Ireland	77
5.4 Building Policy Responses: Conclusions and Recommendations	80
BIBLIOGRAPHY	84

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List of Tables

Table 1: Number of Contacts and Individuals by Source	13
Table 2: Number of Individuals Enumerated in more than One Source	13
Table 3: Cases in Receipt of Help/Support by Main Agency Attended	14
Table 4: Gender Breakdown of Total Valid Cases in Survey	15
Table 5: Individuals in Agency Treatment by Gender Breakdown (Dublin 1 Postal District Only)	15
Table 6: Gender Breakdown in Agency Treatment (Dublin 1 Postal District Only)	16
Table 7: Age Range of those in Treatment Agencies	17
Table 8; Age Range of those on Residents' Lists	17
Table 9: Age Range of those on GPs' Lists	17
Table 10: Age Bands of Drug Users in Three Studies	18
Table 11: Mean Ages of Contacts by Source	18
Table 12; Postal Codes for All Valid Cases in Treatment Agencies	19
Table 13: All Valid Cases in Treatment Agencies from D. 1,7	19
Table 14: Age and Gender Distribution of Individuals from Dublin 1	20
Table 15: Age Group by Gender-All Valid Cases in Treatment Agencies	21
Table 16: No. of Persons by Programme: Dublin 1	21
Table 17: Percentage of Recorded Cases from Each Agency for Dublin 1 Residents	22
Table 18: Number of Visits to Agencies per Person (All Valid Agency Cases)	22
Table 19: Age and Gender Characteristics of Users of More than One Agency	22
Table 20: Postal Districts of Users of More than One Agency	23
Table 21: Multiple Users, Dublin 1 -Pattern of Treatment Visits	23
Table 22: Age and Gender Characteristics of People Attending One Agency and on Waiting List of a Second (All Cases)	24
Table 23: Age and Gender Distribution of Individuals on Waiting List and not in Treatment	24
Table 24: Age Breakdown of Residents' Street Survey Cases	25
Table 25: Age Breakdown of Residents' Street Survey Respondents in Agency Treatment	25
Table 26: Dublin 1 Sample Characteristics	26
Table 27: Age at Which Heroin was first Used	28
Table 28: Age at Which Heroin was first Used	30
Table 29: Age Left School	31
Table 30: Educational and Training Qualifications (Highest Level Attained)	32

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SUMMARY

The Isis Research Group in the Centre for Women's Studies was awarded a grant by Enterprise Ireland (Science and Technology Against Drugs Programme) in January 1997 to investigate in the north inner city of Dublin:

1. the prevalence of heroin drug use;
2. and the experiences of heroin users.

The team collected both quantitative and qualitative data over a ten-month period. The Combat Poverty Agency financed the final stage of the project which entailed mapping research data against current policies in order to locate gaps in policy and service provision. The research project as a whole was conducted in partnership with the Inter-Agency Drugs Project/North Inner City Drugs Task Force.

Chapter One sets out the background to the project, including the context of the north inner city.

Chapter Two describes the multi-enumeration methodology used in the prevalence survey conducted during the last fortnight in May, 1997, which covered five treatment and support agencies in the inner city, these agencies' waiting lists, a residents' street survey, and some local GPs' lists.

Results revealed that the total number of cases of those using heroin and/or methadone at the time of the survey or who had used heroin and/or methadone or heroin substitutes in the six months prior to the survey was 1,657. Of these, there were 477 individuals from the Dublin 1 postal district. There were 433 people in treatment, 3 on waiting lists and 33 not in treatment. The two most heavily subscribed programmes for users from Dublin 1 were methadone maintenance programmes and a drop-in centre.

There was a complete code for 474 of these individuals, of whom 267 were men and 207, women. This gender breakdown for the north inner city, 55 per cent men to forty-five per cent women, differs sharply from the heavily male profile for the Eastern Health Board as a whole.

Of the women, 77.7 per cent were in the age ranges 15-29 years; of the men, 61.8 per cent were in the age ranges 15-29 years. Men and women together made up 11.74 per cent of the sample in the age range of 15-19 years. On the basis of the prevalence data, an estimate of 20.44 users per 1,000 of the total population of Dublin 1 was put forward. It is argued that this figure is virtually certain to be an under-estimate of heroin drug use in Dublin 1.

Chapter Three sets out questionnaire and qualitative data from group interviews that were held in three participating agencies with a self-selecting sample of sixteen people. Of these sixteen, 3 had commenced heroin use before the age of 14 while 9 had commenced use between the ages of 15 and 19. All 16 had extensive prior use with a variety of drugs including alcohol before they commenced heroin use. Of the 12 users who did not inject on their first engagement, 10 went on to inject. All had used illegal means to support their habit. Of the 16 participants, 8 were currently unemployed; 4 were in receipt of a lone parent's allowance; 2 were on a FAS scheme; 1 was in

receipt of disability payment. Only one person was currently employed. All had left school before achieving the Leaving Certificate, 10 leaving between the ages of 13 and 15 years.

Interview data indicated that the involvement of young people in heroin appeared to be fuelled by a volatile combination of a ready availability of the drug and a changing and expansive sub-culture which rates being “stoned” or “wrecked” high in importance. Young people were building a social life around heroin use in the context of a bleak socio-economic outlook for inner city communities. Many were deliberately seeking an alternative lifestyle. Two people only reported turning to heroin after difficult personal and family problems had beset them.

All 16 had tried to self-detoxify at some point. All were daily users by the time they sought formal treatment. Although the reasons people entered treatment differed, all argued that coming off heroin, while hard, was not as hard as staying off heroin. A pattern of relapse was the common experience. It was also a common experience to undertake a number of treatment programmes, many of which proved unsatisfactory. At time of interview, most were stable on a methadone maintenance programme. Two people only were free of all drug dependence.

Chapter Four comprises the data findings from two extended case studies with two individuals living in the inner city who have been drug-free for over one year. Their biographies of heroin use indicated that in the context of the inner city, this way of life is made possible because of a market for heroin that is operating extensively in communities already under siege. Both these young people came from working-class families whose social and economic standing was marginalised, where unemployment or very low status, low paid work were the only options.

These biographies revealed similar findings on treatment to those of the group interviews. Both individuals had faced many failed efforts to get clean and found that staying clean remained a continuing challenge. Both were now pursuing long-term work and re-training options which they saw as important in helping them stay clean.

Chapter Five locates the data from the preceding chapters in the evolving international and national policy debates about responses to illegal drug use. In particular, it reviews eight ethnographic studies on illegal drug use in Britain, the United States and the Netherlands and compares these findings with the team’s findings in the north inner city. The following points of comparison emerge:

- Entry to heroin use through a familiar social network;
- Ready availability of the drug to young people in that network;
- Motivations of curiosity, excitement and “buzz” in initial experimentation;
- When regular use has set in, a lifestyle dominated by the business of heroin;
- Illegal activity to support regular use;
- In British, American, and Irish contexts, hard drug addiction offering an alternative career to young people from marginalised backgrounds;
- Street trade in illegal drugs forms an extensive and expanding market;
- Pattern of multiple efforts at self treatment and available formal treatment to stay off heroin;
- Staying off heroin critically dependent on appropriate treatment and aftercare facilities, including a structured day, to replace heroin-linked activities of funding and sourcing the drug;

- Critical need for long-term training and employment for former users which translate to stable permanent work opportunities.

Chapter Six presents six major conclusions from the study data and specific recommendations. The conclusions are:

1. The decision to use heroin is an active choice taken in a context shaped by several overlapping factors: young people who increasingly experiment with a range of intoxicant/psychoactive drugs as part of a search for an exciting lifestyle; communities which have been offered no significant educational, social or economic benefits by mainstream Irish society; and an illegal market which makes heroin easily available.
2. Regular heroin users support their habit by dealing in heroin and other drugs. Therefore, the pervasive nature of street dealing by drug users must be taken into account when responding to problems of supply, with legal programmes and interventions that realistically respond to the role of the retail illegal street market in sustaining drug use. Alternative models to prison sentences for users charged with dealing and petty crime related to funding their habit need to be assessed, for example, a programme where the user/dealer is offered a choice between prosecution/imprisonment and a rigidly adhered to treatment contract with probation.

The failure of prison sentences to deter dealers who are users or for users charged with petty crime related to the funding of their habit, has been amply demonstrated in the Irish context. This failure has been compounded by the lack of adequate facilities within prison for drug users.

3. Heroin users, in their efforts to come off and stay off heroin, encounter multiple failures before reaching an equilibrium. This means that no one treatment model can be successful and that a fully and adequately resourced drug treatment service must offer an extensive range of treatments and approaches, including long-term counselling and aftercare.
4. The gender breakdown of those in treatment is almost even, five men to four women for the inner city. These figures challenge the prevalent stereotype of the drug user as being an unemployed young male from the inner city. It is critical for policymakers to accept that women are a significant part of the drug-using population, that they report less frequently for treatment, and that they have special needs, especially women with children.
5. The large number of heroin users from the prevalence study from Dublin 1 is directly related to how a heroin sub-culture has flourished in an area which has been gutted by economic restructuring. The problem of heroin use will not be brought under control unless young people are offered best-quality training and employment opportunities in a local economy that has long-term government support and strategic implementation of regeneration plans.
6. Prevention of heroin use will be achieved only by providing a sense of empowerment and self-esteem for young people and their community. Measures must be put in place and sustained to support alternative social and educational programmes which will return a sense of pride to inner city communities.

Specific recommendations are as follows:

1. The standardisation of mechanisms for multi-enumeration data collection, using explicit identifier categories, on heroin and other drug misuse on an annual basis

2. Expansion of the range of services available to include a social model of drugs treatment, including lifeskills work such as reality therapy, art and relaxation techniques.
3. Treatment agencies should be supported to develop active daily schedules for people in recovery, with elements of support, counselling, lengthier detoxification programmes and best quality, long-term aftercare programmes.
4. Women-only programmes and support facilities should be designed for women in treatment, including group work and personal development. Creche and specialist facilities for women seeking residential care must be put in place.
5. Prison treatment programmes should be upgraded and developed to the same standard as those suggested for agencies and clinics outside of prison.
6. More use should be made of Section 28.2 of the 1977 Misuse of Drugs Act which permits the courts to direct an offender towards a treatment programme rather than a custodial sentence.
7. There must be programmes and interventions that realistically respond to the role of the retail illegal street market in sustaining drug use. The medically supervised prescription of pure heroin, on a restricted basis, to long-established addicts who have failed all other treatment programmes and who have long prison records for drug-associated crime should be considered as one way to approach the problem of drug-related crime.
8. GPs who want to treat heroin users in their communities should be adequately resourced in respect of training and back-up facilities to do so.
9. There should be a legal obligation on statutory bodies to provide safe, secure playground facilities, and green areas for inner city residents and their younger children.
10. Peer education programmes that provide a sense of empowerment and self-esteem for young people and that relate to their own knowledge and experience of heroin as a social problem should be developed and supported.
11. There is a need for consistency in policies and resourcing from the Department of Education and Science in relation to the supply, quality and training of skilled teachers to deal with problems of disadvantaged areas.
12. Long-term investment in job creation and training programmes is vital to enhance young peoples' life chances in the North Inner City.
13. A targeted jobs initiative for long-term drug users should also be introduced.

1 BACKGROUND TO THE PROJECT

1.1 ORIGINS

The idea for this project actually extends back to the late spring of 1996 when the Inter-Agency Drugs Project (IADP) drew up a proposal for research to try and establish the extent and pattern of heroin drug misuse in the north inner city.

Indicators of deprivation, such as educational levels and levels of unemployment in the entire inner city area of Dublin, including the north inner city, themselves draw attention to the complexity of the social setting of heroin use. According to the Gamma Study on the Dublin Inner City Partnership Area, between 1986 and 1996, there was an increase of 23 per cent in the numbers of unemployed people in the inner city, compared with a 2 per cent increase in the country as a whole. In 1996, the unemployment rate nationally was 14.8 per cent. The rate in the inner city was 27.3 per cent while the ward in the inner city with the highest unemployment rate was Mountjoy A in the north inner city with a rate of 59 per cent. Forty-three percent of the population in the inner city had left school before the age of 15, compared with 35 per cent in the state as a whole. Seventeen wards in the inner city area had a deprivation ranking of 9 or 10, on a scale of 1 to 10 (Gamma, Report No. 27, 1998).

The IADP (later to become the Northeast Inner City Drug Task Force, one of the 13 local Drug Task Forces set up by government) had been instituted initially by community groups from the north-east inner city and the front-line agencies which were part of the Inner City Organisations Network (ICON) to develop specific community responses to the problem of heroin misuse.

The National Drug Treatment Reporting System has been evolving since 1990 to monitor trends in drug usage (see O'Hare and O'Brien, 1992 and O'Higgins and Duff, 1997). Despite its existence, there was strong anecdotal evidence on the ground in the north-east inner city from individuals, community groups and front-line agency workers to suggest that heroin drug use had substantially worsened. Concerns were expressed that this trend would not be represented in the official drug reporting system due to a number of interrelated problems. The IADP was anxious to quantify the numbers of drug users with a more inclusive, locally-based methodology. However, the agency was concerned that while the Health Research Board reports on treated drug mis-use provided much valuable data, they did not cover people on waiting lists and did not include all the needle exchanges in the ICON area. Most critically, the reporting system, by its nature, could not cover those people not in treatment. The IADP was also concerned about the patterns of multi-drug use about which there was no hard data. The issue of heroin smokers and young drug users, under the age of eighteen, about whom there is scant information was also targeted as a gap.

Thus one overall identified need was to get a much better grasp of the numbers of heroin users in the immediate locality. The significant lack of resources for both the local community and front-line agencies which existed up to the point of major government intervention from the autumn of 1996 onward, had impeded effective responses to the growing numbers of people caught up in a heroin-using lifestyle. This was also a matter of great concern to the IADP. A second and important purpose of the research therefore was

to gain a better estimate of local drug users as concrete evidence of the need for expanded government support for appropriate services in the area.

Events of the summer of 1996, notably the community activism to dislodge pushers and demand better resources in the three key areas of treatment, supply/control and prevention, changed somewhat the parameters of the intended research. In response to community activism, the government began to put in place the plan for Local Drug Task Forces, following on the Ministerial Task Force on Measures to Reduce the Demand for Drugs. Then in the autumn of 1996, a call for research proposals was announced, through FORBAIRT, under the Science and Technology against Drugs Initiative. This created the opportunity for an expanded piece of research on drug use in the north inner city. This expanded proposal was drawn up in close consultation with Liz Riches and two advisors from the subcommittees of the IADP, Jacinta Deignan and Sheila Fogarty.

Establishing more accurate figures on heroin misuse remained a pressing necessity, so the first part of the proposed project, quantitative data on prevalence was largely unchanged in intent. The IADP also saw the importance of investigating the dynamics of heroin drug use in the inner-city area in order to have data on hitherto unexamined issues.

Therefore it was proposed to develop profiles of drug use by carrying out a series of in-depth interviews which could provide detailed information about the way individuals have dealt with drug misuse in their everyday lives: how they came first to engage with heroin; their early patterns of mis-use; and how they have made sense of their lives and needs as heroin users, including the contentious issues of treatment and rehabilitation.

This choice of research methods, using both quantitative and qualitative approaches at different points, highlights the fact that the most important factor influencing the choice of research method, is the purpose of the research (Qureshi, 1992: 140). A quantitative approach would deal with the problem of tracking the incidence and frequency of heroin use while interviews dealt with concepts and categories of meaning around heroin. As Brannen (1992) has argued, multiple methods used to explore different aspects of a research problem strengthens the logic of inquiry and the validity of the conclusions reached.

The final part of the project was a section on policy. The intention here was not to review policy options as such but to critique existing and emerging government policies, drawing on the multiple methods of inquiry and the resulting data collected in the first two phases of the project to develop a strategy of analysis. In other words, this was a grounded approach to drugs policy, identifying from the perspectives of drug users and their communities, the strategic priorities which need to be incorporated into ongoing policy measures as part of a reflexive process of policy-building.

The first two parts of this project were met by the FORBAIRT grant while the Combat Poverty Agency agreed to fund the policy section.

1.2 INITIAL SCOPING WORK

Work on the project began in late January, 1997. The research team saw it as a vital necessity to view the problem of heroin through a number of different eyes. Thus we sought to carry out scoping interviews with:

1. heads of statutory agencies and their workers;
2. heads of voluntary agencies and their workers;
3. users and former users;
4. neighbourhood and community workers and community-led support agencies;
5. medical doctors in general practice.

In the course of eight months' fieldwork, interviews were held with all the above. The team did not interview police although we attended a meeting in the North Star Hotel, organised by the Ana Liffey project, where different models of policing, presented by a Dutch police team were discussed by representatives from voluntary and community groups as well as a Garda spokesman.

1.3 PROBLEMS WITH THE PRESENT SYSTEM OF DATA COLLECTION

The first practical task was to set up the quantitative data collection phase. Meetings with the IADP indicated that the most striking problems in tracking heroin users and their patterns of use were as follows:

- The present system of data collection identifies only heroin users in treatment; individuals are completely omitted from figures if their drug use is private;
- Waiting lists for these agencies are not counted in any of the estimates which form the Drug Reporting System;
- Methadone maintenance clinics must deal only with people who are over eighteen years of age, and who have been using opiates intravenously for one year or longer, excluding younger drug users and those who have been using for shorter periods of time;
- Information sharing between agencies is not easily transferable, due to the need to protect confidentiality; this can create a problem with double counting and multiple counting;
- Not all agencies take part in the Drug Reporting System;
- The existing links between drug users and private GPs are unclear so that drug users may be receiving methadone maintenance and support from GPs but do not appear in agency records;
- Drug users not in contact with agencies may have different profiles and needs to those who are in contact with agencies;
- Scant information is available about the gendered pattern of drug usage;
- Scant information is available on the needs of women heroin users who may also carry the family roles of partners, carers, and parents; for example, mothers who are users who may fear their children will be taken into care if they seek help;
- The patterns in and out of drug use are little researched as yet in the Irish context; in order to develop relevant policies, comprehensive data which is thoroughly grounded in the individual's experience of drug use is required.

1.4 SETTING UP DATA COLLECTION WITH THE AGENCIES

The decision to collect quantitative data on prevalence necessarily led to discussions with the IADP about which agencies were to be included in the survey. The distinction was drawn between agencies and organisations that have drug treatment as a primary role and agencies and organisations that have contact(s) with other drug users offering other types of service provision. The issue of location was also considered: how far away might heroin users in the north east inner city travel for available support services? A list was drawn up of the five major centre city agencies which might be interested in collaborating in the research and whose client base, it was thought, would take in those people in the north inner city searching for agency treatment or support. The agencies were:

1. Ana Liffey Project
2. City Clinic, Amiens Street
3. Merchant's Quay Project
4. National Drug Treatment Centre (Trinity Court)
5. Talbot Centre, Buckingham Street

Each of these has a different remit and distinctive approach to dealing with drug misuse. Four of these agencies have a long-established profile while the City Clinic is a relatively new but important locally-based resource in the north inner city. The City Clinic and the National Drug Treatment Centre offer a range of medical treatment programmes, including methadone maintenance, combined with counselling and group work where appropriate, for their clients. In the case of the National Drug Treatment Centre, their provision also includes in-patient detoxification treatment in Beaumont Hospital. The Ana Liffey Project and the Talbot Centre, although dealing mostly with clients who are using heroin, do not offer any medical treatment, needle exchange service, de-toxification regime or methadone maintenance. Their work is primarily support work, counselling, and befriending. The Talbot Centre has sought to educate and empower young people and their families through a systematic therapy and support service. The Ana Liffey, which operates a daily drop-in service to help create a social dimension in the lives of people caught up in drug use, also deals with issues of skills acquisition and training for recovering drug users. The Merchant's Quay project has a similar emphasis on personal support, counselling and skills training. Its drop-in centre forms an important contact point for heroin users. In addition, it offers a needle exchange programme.

Initial interviews were set up with each of the agencies to secure their participation in the research, to explore their views on the issues surrounding heroin, and to determine the types of data they kept on clients.

1.5 AGENCY OBSERVATIONS ON PATTERNS OF DRUG USE

A number of vital observations emerged in the course of this initial scoping exercise. There was a strong impression that a younger population was now presenting for treatment but whether this reflected a younger population involved with drugs at an earlier age, or more viable treatment facilities or a combination of both was not known. It was thought that often people could be using drugs for as long as 4-5 years before presenting at a treatment centre. The research team was cautioned, however, that the perception of what constitutes 'drugs' differs from person to person. Concern was expressed about the view that alcohol is not viewed as a problematic drug by young people and their families and yet an inappropriate engagement or immersion with it often forms a critical background

experience of a substance which has powerful physical and psychological impacts. On the other hand, there is no single precipitating experience that explains how people come to be involved in drug misuse. There appears to be a huge range of routes into drug use, and a huge diversity of ways of use and ways of living with drugs. One agency worker commented, for example, on a notable upsurge from the beginning of the 1990s in people injecting benzodiazepine, detoxification from which can be a difficult physiological experience. The focus on heroin use, especially injecting heroin use has tended to draw away attention and resources from other groups of drug users and although the increase in heroin use stems from the fact that it is cheaper now, it can often appear any problem less than injecting heroin use is not such a hazardous drug problem. Yet drugs like the injected benzodiazepines can lead to bizarre effects, such as people thinking they are invisible which can thrust them into potentially risky situations.

There was concern, for example, that those young people smoking heroin were not as linked into agency support as they should be. A huge unknown is how many young people who are engaging in drug mis-use are too disaffected to be in touch with any service at all. The comment was also made that younger drug users who had not yet encountered any serious physical consequences of drug mis-use, saw their families as having the problem with drug use, not themselves.

It was suggested that the organisation of clinical treatment for drug use is too much an expression of the medical model of approach to heroin and too complex; the structures of particular programmes and waiting lists, for example, can have a negative impact on people who present for treatment. People require immediate attention but attendance is regulated by an appointment system, governed by available time slots (which is a resource issue) and governed also by such clinical procedures as urine testing. Between clinics, there is a variation on the dosages of methadone given in maintenance programmes. Within the same clinic, great efforts have usually been made to find the most suitable programmes for attendees. However, access and entry criteria, such as how long one has been injecting or how many clean urine tests are needed, reflect different and frequently contested perspectives within the medical profession on what constitutes the most successful forms of treatment. This can often result in a gap of understanding between the way specific programmes are conceptualised and the ways people are actually living their lives, reducing the effectiveness of treatment programmes. People may feel the need to put their names down on several waiting lists in the hope of ending up on some programme rather than none at all. Yet this may not be what they need. On the other hand, a long waiting period for a particular treatment programme can wipe out a drug user's intentions to seek help. Potentially, the local GP can offer more rapid access.

Finally, it was observed that while a person is caught up in a cycle of drug use, s/he is also dealing with all the usual dilemmas of daily life. People may want to seek help about family relationships or coping with children at least as much as help and advice about drug use per se. Specific groups of clients, like pregnant women, need services tailored to their situation but these are not available within the ambit of drug treatment clinics. There is a huge challenge set for agencies in not problematising their clients to the point where their lives are overdetermined by the categories of counselling and clinical treatment, as necessary as these are.

All these points of discussion and issues became 'foreshadowed problems' (Hammersley and Atkinson, 1989: 28-32) which we hoped would be explored in the course of the fieldwork.

1.6 AVAILABLE DATA SOURCES AND PROBLEMS OF CONFIDENTIALITY

All the agencies were willing to co-operate in data collection for the various phases of the research but all were deeply concerned about the issue of confidentiality and how this could be guaranteed. The agencies kept different sorts of quantitative data, on quite different types of forms which was another factor that required attention. The possibility of the research team accessing record forms was discussed, primarily as a way to prevent putting the staff of each of the agencies under further work pressure. This was rejected as unfeasible because of the problem of confidentiality. Even indirect access through any data collection form the research team might design was still seen as problematic. Two agencies indicated that they would want to approach their clients directly to ask their permission on the sharing of data with the research team.

Views were also offered on what window of time might best capture the current pattern of prevalence, given both agency resources and variations in agency use such as can come about during the summer months. The difficult problem of accessing information on those not in touch with support agencies was also raised. This last issue was tackled by the IADP, which through its newly-appointed community liaison worker, hoped to put the research team in contact with nine residents' associations which are locally active in helping to support drug users and their families in the north inner city area. The community liaison worker, Joe Dowling, was already running courses for representatives from these groups and it was felt that the research team would be able to access good quality data on users from this direction. It was also hoped that the research team would be able to make contact with GPs in the area who might be treating drug-using patients independent of the main drugs support agencies.

2 THE PREVALENCE SURVEY

2.1 DESIGNING AND PILOTING DATA COLLECTION SHEETS

The 1996 report from the National Drug Reporting System, *Treated Drug Misuse in Ireland*, indicates that a number of factors operate in the collection of data which would lead to the underestimation of treated drug misuse, including resource issues for the treatment centres concerned; non-inclusion of GPs who prescribe for patients; and non-inclusion of treatment within the prison service (O'Higgins and Duff, 1997: 2,5). On the other hand, the report notes that the lack of a unique identifier system for each client in Ireland means that unlike other European countries with this system, there can be overlap between agencies resulting in double-counting (ibid.: 5).

Having reviewed these problems with data collection along with the agencies' perspectives, and following feedback from the IADP and advisors to the project, a pilot form for data collection was drawn up. With help from the agencies and the IADP, a data sheet was designed to request information on all users of heroin, and/or methadone, and/or other heroin substitutes in the previous six months. The sheet contained bands of information which, when filled out, would supply a unique identifier code for each client in all of the five agencies during the survey period and all additional survey sources, including local residents' associations and GPs. The code would identify drug users who were in touch with more than one agency, eliminating the problem of double-counting.

This 'Soundex' code was comprised of the following:

1. initials of first name and surname;
2. gender;
3. date of birth;
4. postal district.

The agency data form was piloted with each of the five participating agencies at the same time that a separate form was piloted for the local residents' associations. After a meeting with representatives from the associations and the community liaison worker of the IADP, a form with some additional columns of information was designed. These included whether people were in treatment or not and whether or not they were or had been using heroin, injecting or otherwise in the previous six months. There was a strong argument put in favour of trying to access such information; local people felt that it was important data for helping to further develop support work and that they would be able to gain a sufficient response to make this worthwhile. The research team felt such data would complement agency data in an important way.

After all necessary changes to the forms had been made, the final dates were set for the data collection period and forms were despatched to the agencies. Contact was also made with several GPs in the area who were prescribing methadone or other forms of treatment for heroin drug mis-use and who agreed to fill in the forms. In the case of the residents' groups, a further preparation meeting was held to discuss working with the forms.

The survey period extended from the 19th of May to the 1st of June, 1997, including Saturdays and Sundays, where relevant. There was a separate form to collect the same core information on all people on agency waiting lists during that period. Forms were collected in the week following the end of that period and participants were asked to comment at that point on any problems they had encountered.

2.2 PROBLEMS ENCOUNTERED CARRYING OUT THE SURVEY

Notwithstanding the issue of time incursions to do the work, the agencies had little difficulty in carrying out the survey, whether they gathered the figures from each of the programmes within the agency on a daily or weekly basis, or retrospectively in the week following the survey period, using agency records. Separate sheets were filled out for either actual visits or people on the waiting lists for each day of the survey.

However, the survey period coincided with a sudden drought in available heroin. Heroin was reported as having returned to the average street price of 1994, that is £40 per bag¹, after a low of £7 per bag during 1996. It proved difficult to obtain although agencies could not confirm whether the diminished supply was due to the imprisonment of one of the major dealers in the area during this period, to increasingly effective searches by the Garda which had driven dealers back to the margins, to increased community action against local dealers, to an artificial drought created by dealers to drive up the price, or a combination of all these factors.

Two of the agencies felt that the drought had contributed to a downturn in numbers of heroin users. In the case of one, figures indicated a drop of perhaps a third in the usual client base, and those clients who were seeking a specific service from this agency complained of difficulty in sourcing heroin. The second agency suggested that there might be a resurgence of very young people on tablets such as the benzodiazepines and a shift in patterns of those who usually smoked heroin because of the drought. However, very little is known about the choices which are made under such circumstances and how or whether users might turn to other substances such as hash, cocaine, ecstasy or tablets as alternatives.

The other three agencies reported no unusual fluctuation in numbers.

The unanticipated drought of heroin had consequences for carrying out the prevalence survey at street level. What appeared to be a rise in tensions also appeared to lead to a deepening resentment of those seeking information and these factors impacted on the ability of the residents' associations to collect data. At the end of the survey period, very few forms were returned. Nonetheless the very limited data from this source and from two local GPs who agreed to participate, indicated that it could be very useful to replicate this data-gathering exercise at some point in the future.

2.3 SURVEY RESULTS: AN OVERVIEW OF MAIN DATA FINDINGS

By source of information, the prevalence survey broke down as follows:

1 A bag generally holds one-sixteenth of a gram.

Table 1: Number of Contacts and Individuals by Source

Source	Number of contacts	Number of Individuals
Treatment Agencies *	5,645	1,480
Waiting Lists	917	92
Residents Groups Lists	51	51
Local GPs Lists	34	34
* Note, there were 5,707 data items from the treatment centre data, but of these 62 (1%) could not be ascribed to individuals because of gaps in information for the Soundex identifier.		

All data entries were inputted and checked for validity. Of the agency data, just under 99% of the entries had the complete Soundex identifier and were able to be entered; the remaining entries, which had gaps in information on date of birth, were eliminated because they could not then be cross-checked. Of the residents' data and GPs' data, 85 entries were valid.

The Soundex code was used to filter out double-counting in the following area:

1. multiple visits within agencies: the result of the same person having multiple attendances during the two-week period in the same programme at the same agency, for example, a methadone maintenance programme.
2. instances where people were on residents' lists or GPs lists as well as agency lists.

The table below sets out information on individuals who were counted in more than one agency or source as distinct from multiple visits to the same agency or source:

Table 2: Number of Individuals Enumerated in more than One Source

Source	Other Treatment Agencies	Waiting Lists	Residents Groups' Lists	Local GPs List
Treatment Agencies	121	49	10	33
Waiting lists	49	n.a	0	0
Residents Groups Lists	10	0	n.a	0
Local GPs Lists	33	0	0	n.a
* n.a. = not applicable.				

Included in the 1,480 agency cases were 121 cases where users were on the lists of more than one agency. In 118 of these 121 cases, users were on the lists of two agencies only. In 3 instances, users were on the lists of three agencies. These figures are explicable in the context of a heterogeneous agency sample which included the Merchant's Quay and Ana Liffey projects, alongside two medically-run clinics dealing with large methadone maintenance programmes. More complete data on this is presented below in the section on users of more than one agency.

In relation to the agency waiting lists, there were 92 separate Soundex entries, comprising the total number of individuals on those lists surveyed over the fortnight. As indicated in the Table above, 49 individuals were receiving some form of treatment or support from one of the agencies while on a waiting list for another programme or additional forms of therapy either in the same agency or a second agency. However, 43 of the people on waiting lists were not receiving any treatment at all from any of the agencies surveyed.

Only 10 of the people contacted as part of the residents' street survey were in treatment programmes of any type. If the street survey had been more successful, we would have a far better idea of the quality of data that could be obtained in this way. But it is worth bearing in mind that even with this very small sample, most of the 51 people contacted in the Dublin 1 area were not in treatment anywhere else at all.² This underlines the significance of doing street surveys, working through residents' groups, to try and plot with greater consistency the size of the population not in contact with any drugs treatment or front-line agency. It also underlines the value of carrying out a survey with multiple points of contact in order to try and gain as true a snapshot as possible. In the GPs data, 33 people were receiving care and support from another agency while only 1 person was not. This may be an indication of the important medical role that GPs can carry out with drug users in tandem with support programmes of the larger agencies.

In all, the main overlap was people already in treatment and support agencies.

The 1,480 active cases in treatment and support agencies (including those in treatment with more than one agency) were distributed as follows:

Table 3: Cases in Receipt of Help/Support by Main Agency Attended

Agency	Numbers	Percentage
City Clinic	345	23.3%
Merchants Quay	502	33.9%
Ana Liffey	160	10.8%
Talbot	20	1.4%
Trinity Court	453	30.7%
Total	1,480*	100%
<i>* Of these 1,480 cases, 118 people attended two different agencies; 3 people attended 3 different agencies.</i>		

² One individual listed on the street survey died very shortly afterwards.

The overall gender breakdown was as follows:

Table 4: Gender Breakdown of Total Valid Cases in Survey

Data Source	Male	Female
Treatment Agencies	970	507
Agency Waiting Lists	59	33
Residents' Groups Lists	29	22
Local GPs Lists	18	16
Total	1076	578
<i>Note: Missing Cases - 4 - gender not recorded for these cases</i>		

Women comprised 53.7 per cent of the sample overall but these figures beg closer examination. The gender breakdown of those in treatment agency programmes alone was:

Male: 65.7%
 Female: 34.3%

This predominance of men in the agency data, on a 2 to 1 ratio, corresponds to findings on gender in the sample group interviewed in the 1997 study on heroin use in the South Inner City (McCarthy and McCarthy, 1997). The gender breakdown in the data from the National Drug Reporting System for the Eastern Health Board region indicates an even greater predominance of men seeking treatment, 71 per cent of all contacts, compared with 29 per cent of women (Moran, O'Brien and Duff, 1997:43)³. However, in our survey, the balance between men and women in agency treatment changed when viewed by postal district. This revealed the following breakdown for the Dublin 1 postal area:

Table 5: Individuals in Agency Treatment by Gender Breakdown (Dublin 1 Postal District Only)

Gender	Number	Percentage
Men	240	55.8 %
Women	190	44.2%
Total	430	100%

By agency, the gender breakdown for Dublin 1 users was as follows:

3 The figure for contacts from the NDRS are for all treated drug mis-use, so these figures will include more than just heroin users. But the authors state that in the greater Dublin area, the predominant problem of treated mis-use is heroin at 80%, followed by other opiates at 11% (Moran, O'Brien and Duff, 1997:27).

**Table 6: Gender Breakdown in Agency Treatment
(Dublin 1 Postal District Only)**

Agency	Men	Women
Ana Liffey	45	27
City Clinic	157	139
Merchant's Quay	22	11
Talbot	6	4
Trinity Court	10	9
Total	240	190

With much smaller samples in the residents' lists and the local GPs lists, there was a closer ratio still between men and women. This also suggests that women may experience difficulties in accessing agency help.

This much closer ratio raises issues about the importance of locally-based support and treatment services which cater specifically for women's needs. The Ana Liffey project, for example, has been developing its services for some years to make them as user-friendly as possible for women with children to attend. During agency interviews and in interviews with users, it was suggested that the greater proportion of men seeking treatment relates to the greater difficulties women have in seeking treatment, very often because of fears of disruption to their families and relationships, including children. This gender problem is borne out in the literature on drug use which demonstrates that women with children are far less likely to approach treatment facilities because they fear their children being taken from them (see for example, Bourgois, 1997; Taylor, 1992). Despite the fact that women are using in increasing numbers, there are other barriers to treatment, including the way referral networks are organised. Statistics in the United States indicate that the crack cocaine problem is one in which women use equally as men but treatment protocols and after-care programmes are male-based (Bourgois, 1997; National Institute on Drug Abuse, 1993). Here in Ireland, the recent study of women prisoners in Ireland (Carmody and McEvoy, 1996:7-8) indicates that 60 of 75 women prisoners were drug users; 59 were using at the time of imprisonment; 57 of these were heroin users. So as a whole this is a substantial aspect of drug use and drug treatment which requires more attention.

The distribution of age groups in treatment with agencies for the entire sample was as follows:

Table 7: Age Range of those in Treatment Agencies

Age Groups	No. in Treatment Agencies
11-14 yrs	1
15-19 yrs	181
20-24 yrs	449
25-29 yrs	388
30-34 yrs	265
35-39 yrs	123
40-44 yrs	42
45-49 yrs	17
50-59 yrs	1
60-64 yrs	1
65 yrs+	1

Note: Missing Cases -12 - age not recorded for these cases

For the residents' lists, the age breakdown was as follows:

Table 8: Age Range of those on Residents' Lists

Age Group	No. of Individuals
15-19 yrs	6
20-24 yrs	21
25-29 yrs	4
30-34 yrs	8
35-39 yrs	3
40-44 yrs	2

In the GPs data, the age breakdown was:

Table 9: Age Range of those on GPs' Lists

Age Group	Number
15-19 yrs	6
20-24 yrs	14
25-29 yrs	9
30-34 yrs	3
35-39 yrs	0
40-44 yrs	1
45-49 yrs	0
50-59 yrs	0
60-64 yrs	0
65 yrs+	1

The youngest user, in the 11-14 years age group, was in a residential programme.

The contemporary pattern of heroin use in western society indicates that this is a young people's preoccupation. The literature is reasonably consistent on the point that users can have a previous experience of a wide range of drugs, including alcohol, which may start in very early adolescence (see Bourgois, 1997; Parker et al., 1988; Pearson, 1987; Taylor, 1993, for example). But involvement with heroin is also bound up with the youth culture of a locality. It appears that some young people engage in using heroin and disengage before they cross a border into addiction (Parker, 1988: 50; Pearson, 1987: 81). On the other hand, when heroin begins to assume a central place in local youth culture, "a smack-head can even assume something of a heroic status' (Pearson, 1987:41). What the statistics on age point out is that if people become addicted, their reliance on heroin will form a core experience of their young adult years. The validity of this can be seen by viewing side by side the age data from the 1997 South Inner City study (McCarthy and McCarthy, 1997), the National Drug Reporting System figures for the Eastern Health Board (Moran, O'Brien and Duff, 1997) and this current IADP study. Although there are great differences in sample size and type,⁴ the great majority of users in all three samples are young people under the age of 30.

Table 10: Age Bands of Drug Users in Three Studies

SIC	NDRS	IADP
17-19 yrs 15%	15-19 yrs 28.6%	15-19 yrs 12.3%
20-23 yrs 46%	20-24 yrs 34.4%	20-24 yrs 30.6%
24-28 yrs 23%	25-29 yrs 16.8%	25-29 yrs 26.4%
Total: 84%	Total: 79.8%	Total: 69.3%

Moran et al. (1997: 25) note that according to the cumulative figures from the National Drug Reporting System, 1990-1996, the age profile of the drug user is getting younger in Ireland. The mean age reported there for all contacts, which includes all forms of drug misuse is 24 (ibid.). The mean ages for all the cases of heroin mis-use alone in our study is 27.1. Broken down by source, the ages are as follows:

Table 11: Mean Ages of Contacts by Source

Source	Mean Age
Treatment Agencies	27.16
Waiting Lists	27.9
Residents' Lists	24.9
GPs Lists	27.0

The mean age of those in treatment agencies differs by gender. For men, the mean age is 27.9 years whereas for women, it is younger at 25.7 years.

The distribution of postal addresses for all valid cases in treatment with agencies was as follows:

⁴ The data from the SIC study (McCarthy and McCarthy, 1997 and the IADP study concerns heroin users only. The National Drugs Reporting System figures refer to all treated drug misuse in the Eastern Health Board but the authors also state that heroin is the primary drug of misuse. Moreover, in the Eastern Health Board region (Moran, O'Brien and Duff, 1997:43,45).

Table 12: Postal Codes for All Valid Cases in Treatment Agencies

Postal District	Number	Percent
Dublin 1	433	30.4%
Dublin 2	33	2.3%
Dublin 3	29	2.0%
Dublin 4	9	0.6%
Dublin 5	31	2.2%
Dublin 6	20	1.4%
Dublin 7	156	10.9%
Dublin 8	214	15.0%
Dublin 9	26	1.8%
Dublin 10	44	3.1%
Dublin 11	117	8.2%
Dublin 12	83	5.8%
Dublin 13	6	0.4%
Dublin 14	9	0.6%
Dublin 15	25	1.8%
Dublin 16	6	0.4%
Dublin 17	34	2.4%
Dublin 20	4	0.3%
Dublin 22	40	2.8%
Dublin 24	37	2.6%
Dublin 30	9	0.6%
Co. Dublin	37	2.6%
Dun Laoghaire	1	0.1%
Co. Louth	3	0.2%
Co. Meath	4	0.3%
Co. Kildare	1	0.1%
Co. Clare	1	0.1%
No fixed address	14	1.0%
Total	1,426	100%

Isolating the agency cases for postal districts in north inner city Dublin yielded the following breakdown:

Table 13: All Valid Cases in Treatment Agencies from D. 1,7

Postal District	Number	% of 1,426 Valid Cases in Treatment
Dublin 1	433	30.4%
Dublin 7	156	10.9%

If it can be taken that the postal districts for Dublin 1 and 7 more or less approximate to the North Inner City Borough Electoral Area, then the total figures for Dublin 1 and 7, that is, 589 cases, can be compared with the figure of 642 contacts from the North Inner City from the National Drug Reporting System during 1997 (Moran, O'Brien and Duff, 1997:34). Of our 589 cases for Dublin 1 and 7, there were 63 who were using more than 1 agency.

Adjusting for double-counting, in Dublin 1 postal district, our survey contained a valid count amounting to 477 individuals from all sources:⁵

- agency cases (433),
- waiting lists of those not in treatment at all at present (3);
- residents' lists (41)

Crosstabulated by age and gender, the dispersal of these individuals in the Dublin 1 area is as follows:

Table 14: Age and Gender Distribution of Individuals from Dublin 1

Age-Group	Men	Women	Men (%)	Women (%)	Total (%)
15-19 yrs	22	28	8.24	13.5	10.5
20-24 yrs	58	75	21.72	36.2	28.1
25-29 yrs	85	58	31.84	28.0	30.2
30-34 yrs	62	34	23.22	16.4	20.3
35-39 yrs	27	10	10.11	4.8	7.8
40-44 yrs	9	1	3.37	0.5	2.1
45-49 yrs	4	0	1.50	0.0	0.8
50-54 yrs	0	1	0.00	0.5	0.2
Total	267	207	100%	100%	(474)

Note; There are 3 cases in treatment in Dublin 1 for whom age information is unavailable. Therefore the total number of individuals in Dublin 1 is 477

2.4 PATTERNS OF USE WITHIN THE TREATMENT AGENCIES

Below is presented data on age and gender for all valid cases in treatment agencies:

⁵ NB. There were no GP cases from Dublin 1 which were not also in an additional support agency programme; they are counted here with the agency cases.

Table 15: Age Group by Gender - All Valid Cases in Treatment Agencies

Age Group	Male	Female
11-14 yrs	0	1
15-19 yrs	100	81
20-24 yrs	271	177
25-29 yrs	255	131
30-34 yrs	187	78
35-39 yrs	100	23
40-44 yrs	36	6
45-49 yrs	15	2
50-59 yrs	0	1
60-64 yrs	1	0
Sub-Total	965	500
Total	1,465	
<i>Note: Missing cases = 15</i>		

This crosstabulated data on age and gender for all valid cases in treatment agencies gives a good indication of how necessary it is to have ongoing support around all the possible forms of treatment. Just 43 per cent of the treatment sub-sample was between the ages of 15-24 years. If the age profile of the drug user is getting younger, it is all the more critical that appropriate treatment services are readily available, in order to support these younger users to move away from the drug and stay away from it, rather than to have their involvement prolonged. However, there is an acknowledged pattern of decision-making about seeking treatment which is linked to an acute problem of sustaining motivation for the user who decides to seek help or treatment. S/he will require the serious sympathetic support of family or friends as well as appropriate and expert professional help which can be accessed without delay (Pearson, 1987:155). Lacking a fully supportive framework, a very common pattern for users is to ‘become trapped in a cycle of abstinence/relapse’ (ibid.: 158-9). This issue is discussed in the section on profiles, below.

For users from the Dublin 1 area, the most heavily subscribed programmes were as follows:

Table 16: No. of Persons by Programme: Dublin 1

Programme Type	Number	% of Dublin 1 Cases
Maintenance	138	31.9
Drop-in	71	16.4
Smokers	62	14.3
Interim	59	13.6
Mobile Clinic	40	9.2

The dispersal of individuals from Dublin 1 among the five treatment agencies was distributed as follows:

Table 17: Percentage of Recorded Cases from Each Agency for Dublin 1 Residents

Clinic	D.I Number of Total Recorded Cases	D.I Percentage of Total Recorded Cases
Ana Liffey	72	45.0%
City Clinic	299	86.7%
Merchant's Quay	33	7.4%
Talbot	20	50.0%
Trinity Court	19	4.2%

During the fortnight, the following pattern of multiple visits to agencies emerged:

Table 18; Number of Visits to Agencies per Person (All Valid Agency Cases)

Number of Visits	Number of Cases	% of Total Cases
One visit	764	51.6%
Two visits	157	10.6%
Three visits	77	2.0%
Four visits	53	3.6%
Five visits	54	3.6%

Two hundred and eight cases had between 6 and 10 visits; 146 cases indicated between 11 and 15 visits; 17 cases had between 16-20 visits. Five cases were listed as between 21 and 29 visits. These figures raise the issue of frequency of use: which service/programmes of each of the agencies is more used; which less frequently used and why. This issue will be taken up again in the section on profiles.

2.5 MULTIPLE SERVICE USERS AND WAITING LISTS

The age and gender characteristics of the 121 cases of users of more than one agency are set out below:

Table 19: Age and Gender Characteristics of Users of More than One Agency

Age Group	Male	Female	Total
15-19 yrs	1	6	7
20-24 yrs	17	20	37
25-29 yrs	23	15	38
30-34 yrs	13	9	22
35-39 yrs	6	6	12
40-44 yrs	4	0	4
45-49 yrs	1	0	1
Total	65	56	121

The breakdown of these multiple users by postal district is as follows:

Table 20: Postal Districts of Users of More than One Agency

Postal District	Number	Percent
Dublin 1	48	40.3%
Dublin 2	3	2.5%
Dublin 3	2	1.7%
Dublin 4	1	0.8%
Dublin 6	3	2.5%
Dublin 7	15	12.6%
Dublin 8	14	11.8%
Dublin 10	3	2.5%
Dublin 11	11	9.2%
Dublin 12	4	3.4%
Dublin 17	1	0.8%
Dublin 22	5	4.2%
Dublin 24	2	1.7%
Dublin 30	1	0.8%
No Fixed Address	3	2.5%
Co. Dublin	3	2.5%
Total	121	100%
<i>Note: Missing Cases = 2</i>		

The largest single group of multiple agency contact cases, 48, comes from Dublin 1, followed by Dublin 7 and Dublin 8. Dublin 11 contributes just under 10 per cent to the total. This data may suggest that drug users seeking treatment in the inner city areas are motivated to make choices about their needs, given sufficient and appropriate resources. The data may also suggest that people will travel in to inner city Dublin in order to make use of services - 30 per cent of the valid cases are in that category.

The treatment visits of those 48 multiple users from Dublin 1 were distributed as follows:

Table 21: Multiple Users, Dublin 1 - Pattern of Treatment Visits

Programme	Frequency	Percent
Maintenance	267	39.7%
Drop-in	195	29.0%
Interim	83	12.4%
Mobile Clinic	53	7.9%
Asterisk	34	5.1%
Maintenance-Detox	12	1.8%
Smokers	11	1.6%
Counselling	6	0.9%
Evening Programme	6	0.9%
Contact	3	0.4%
One to One	2	0.3%

It is significant that a third of these multiple visits relate to social support offered, by drop-in, training and counselling programmes. Given the extent to which the life of the heroin

user, once s/he seeks treatment is governed by the administration of the medical programmes like training, it is critical that good quality social support programmes are also available to help enable people to reconstruct their lives and reintegrate themselves in activities which correspond to other dimensions of their lives.

The data on individuals who are attending one agency and on the waiting list of a second agency are presented below by age and gender:

Table 22: Age and Gender Characteristics of People Attending One Agency and on Waiting List of a Second (All Cases)

Age Group	Male	Female	Total
15-19 yrs	2	1	3
20-24 yrs	7	7	14
25-29 yrs	11	7	18
30-34 yrs	7	1	8
35-39 yrs	6	0	6
Total	33	16	49

Sixteen of these people were attending Merchant’s Quay; 1 was attending the Ana Liffey; and 32 were attending Trinity Court. The waiting lists where they had their names down were the Stabilisation programme, Merchant’s Quay (11) and the residential programme, Trinity Court (38). Only 1 of these 49 was from Dublin 1 postal district. There was only one person from Dublin 1 who was attending one agency and on the waiting list for another.

Finally, age and gender data is presented on 42 of the 43 people who were on a waiting list but not in treatment.

Table 23: Age and Gender Distribution of Individuals on Waiting List and not in Treatment

Age-Group	Men	Wome	Total %
15-19 yrs	2	0	4.8
20-24 yrs	5	3	19.0
25-29 yrs	6	9	35.7
30-34 yrs	7	3	23.8
35-39 yrs	4	2	14.3
40-44 yrs	1	0	2.4
Total	25	17	(42) 100%

There is 1 individual in treatment and on the waiting list for whom age-group information is unavailable. Therefore the total number of persons on the waiting list and not in treatment is 43.

We were not in a position on the survey form to ascertain how long people had been waiting for treatment. But as we have already discussed, the issue of immediate access is key to developing an effective support strategy for heroin users. Of these 42, there were only 3 from Dublin 1, all men, aged between 20 and 39 years of age.

2.6 DATA FROM THE RESIDENTS’ STREET SURVEY

Of the 51 people picked up by the residents’ street survey, of whom 22 were women and 29 men, the age breakdown was as follows:

Table 24: Age Breakdown of Residents' Street Survey Cases

Age	Number	Percent
15-19 yrs	13	25.5%
20-24 yrs	21	41.2%
25-29 yrs	4	7.8%
30-34 yrs	8	15.7%
35-39 yrs	3	5.9%
40-44 yrs	2	3.9%
Total	51	100%

There were only 10 individuals who were picked up by the residents' street survey who were in treatment. They were dispersed amongst treatment agencies as follows:

Table 25: Age Breakdown of Residents' Street Survey Respondents in Agency Treatment

Agency	Number
City Clinic	4
Merchant's Quay	2
Ana Liffey	1
Talbot	1
Trinity Court	1

There were five men and four women in this group.

2.7 SUMMARY OF DATA FINDINGS FROM PREVALENCE SURVEY

The prevalence survey used data gathered from the following sources during the fortnight of 19th May-1st June, 1997:

- Five Treatment and Support Agencies;
- Agency Waiting Lists;
- Residents' Street Survey;
- 2 GPs Lists

The total number of cases which were tracked of those using heroin and/or methadone at the time of the survey or who had used heroin and/or methadone or heroin substitutes in the six months prior to the survey was 1,657.

Of these 1,657 cases, there were 477 individuals from the Dublin 1 postal district. The Dublin 1 sample can also be categorised by the following characteristics:

Table 26: Dublin 1 Sample Characteristics

Location	Number of Individuals
In Treatment/Support Agencies	433
Users of More than One Agency	48
On Agency Waiting Lists (not in treatment)	3
In Treatment and on Another Agency Waiting Lists	1
On GPs Books	20
Residents/Lists (not in treatment, not on waiting	41
<i>Note: Numbers add up to more than 477 because they appear in different locations.</i>	

Of those entries for Dublin 1, with complete information on gender, there were 267 men and 207 women. Of the women 77.7 per cent were in the age ranges 15-29 years; of the men, 61.80 were in the age ranges 15-29 years. Taking men and women together from Dublin 1, of the total sample of 477, 11.7% per cent were in the age range of 15-19 years.

For users from the Dublin 1 area, the two most heavily subscribed programmes were methadone maintenance programmes and the drop-in centre.

Parker et al. (1988) argue that despite the very real difficulties of trying to achieve an accurate estimate of prevalence, locally-based multi-enumeration type surveys, such as this IADP study, when combined with large-scale long-term longitudinal data -similar to the data produced by the National Drug Reporting System - can begin to offer a basis for valid data comparisons between localities and over time. Our overall figure for Dublin 1 is bound to be an underestimate. We did not cover all GPs in the area nor were all local residents' groups able to collect data. Even if these sources had been viable, there would still have been an unknown percentage of users, not in contact with any treatment agency or known to local networks and groups who would have not been counted.

Notwithstanding these considerable difficulties, and allowing for all the methodological problems with the data in our prevalence study, including incomplete Soundex identifiers; and very limited coverage outside the scope of the treatment and support agencies, we have emerged with a figure of 477 heroin users and/or users of methadone and/or people who were using heroin and/or methadone in the six months up to and including the survey period. The NDRS report lists 642 contacts with treatment agencies for people (all contacts and all forms of drug mis-use) from the North Inner City⁶ for 1997 (Moran, O'Brien and Duff, 1997:4). In a recent study for the Department of Health, not yet published, there were 183 male users from Dublin 1, aged between 15-24, drawn from hospital and police data (Personal communication, Catherine Comiskey). Our study emerged with 80 men in that age group.

It is clear from our study that a more refined and comprehensive survey approach is very necessary to incorporate all possible sources of data with a Soundex identifier in order to establish more accurately prevalence levels. Certainly the Soundex identifier has worked quite well in constructing the data base which is part of this current study.

6 The North Inner City District Electoral areas include streets from both Dublin 1 and Dublin 7 postal districts.

But now, for the sake of argument and experimenting with the possibilities of the data which is incomplete, we can see if we can arrive at the very roughest estimate of heroin users per 1,000 of the population. The population for the postal district of Dublin 1 was 23,344 in 1996, according to the CSO.⁷ Based on our prevalence of 477 users, this gives us an estimate of 20.44 users per 1,000 of the population, which is virtually certain to be an under-estimate for the reasons outlined above. Nevertheless, this is the kind of demographic figure which we require if we are to map the use of heroin both between geographical areas or districts and over time. This is vital baseline data for policy development. The data also gives points of comparison around age and gender of known heroin users.

This prevalence study therefore forms a first step in trying to gather in this type of data. The agencies were able to handle the forms and therefore we know that an identifier code like Soundex does work. This work needs to be built on at local level to refine and extend data sources in order to be able to track what is happening with heroin in the north inner city. For example, the figure on smoking heroin is an important example of a trend which can be monitored from this data base. In the survey, there were 62 smokers using that treatment programme in the City Clinic. The programme is a relatively new one in the clinic, in response to a perceived need in the area locally. According to the NDRS, intravenous drug use has become less common while smoking heroin has been increasing (Moran et al., 1997: 26-27). This is also a younger population, according to Moran et al (ibid.). The local prevalence data on smoking, contained in this study, along with NDRS reported trends, may help to form a basis of comparability for charting future trends and therefore future treatment needs.

7 This figure is arrived at by mapping the streets for each borough electoral area against the streets which are in Dublin 1 postal district. Four streets, which are in Inns Quay C, were excluded from this mapping exercise we have undertaken, as they are in postal district 7.

3 PROFILES

3.1 INTRODUCTION

Heroin use is a context-bound problem. C. Wright Mills (1940) has argued that the vocabularies of motive and action which people develop originate in the situation in which people find themselves. People must then develop what he terms ‘an appropriate vocabulary of motives’ to make sense of their situation and of the actions they take. To amplify the context of heroin, its meanings for people, how people account for their engagement with heroin and the accompanying lifestyle, the research team conducted a series of group interviews and two extended case studies of former drug users. These latter are presented in the next chapter.

The group interviews were carried out with the help of the three non-medical facilities or agencies who had assisted in the prevalence study. Each of these three agencies, the Ana Liffey Project, the Merchant’s Quay Project and the Talbot Centre, approached people who were in treatment with them and asked them if they would be prepared to engage in interviews which would be audio-recorded. Complete confidentiality was a key issue for the agencies and for those who participated. They were assured that any identifying details would be removed in using the data. All names used in the resulting data are pseudonyms. The group interviews lasted on average about one and a half hours. There were sixteen participants in all, 2 men and 14 women, given the relative paucity of research data about women heroin users (Taylor, 1992) and the predominance of men in treatment, it is both interesting and useful that more women than men participated. Two of these people were interviewed separately at their request rather than as a joint interview. An interview schedule was used to guide the interviews, based on issues which had been raised in the course of the initial scoping work and the prevalence study.

3.2 SOCIO-ECONOMIC CHARACTERISTICS FROM QUESTIONNAIRE DATA

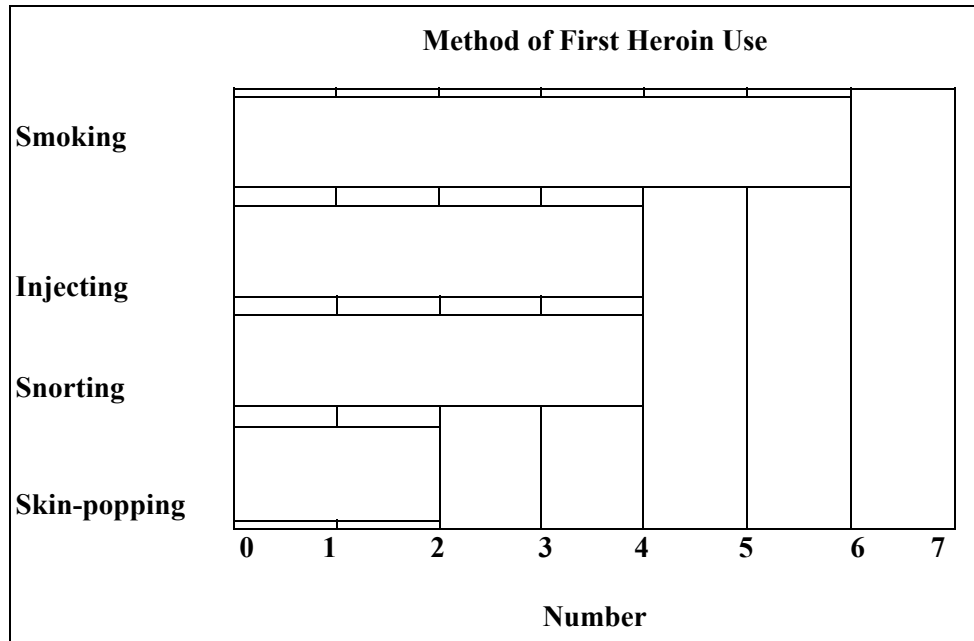
Before the interviews commenced, the research team invited each participant to fill out a brief questionnaire with details on the age when each first started to use heroin, subsequent pattern of use, prior drug use, and history of treatment, in addition to socio-demographic information on age, schooling and work. This data is now presented.

The problem of heroin as a young person’s experience is underscored again in answers to the question on what age people were when they first engaged. Only two people were 20 years + when they first got involved, the eldest being 22 years:

Table 27: Age at Which Heroin was first Used

Age Group	Female	Male	Total
10-14	3	0	3
15-19	9	2	11
20-24	2	0	2
Total	14	2	16

The first time each used heroin, the chosen mode of use was:



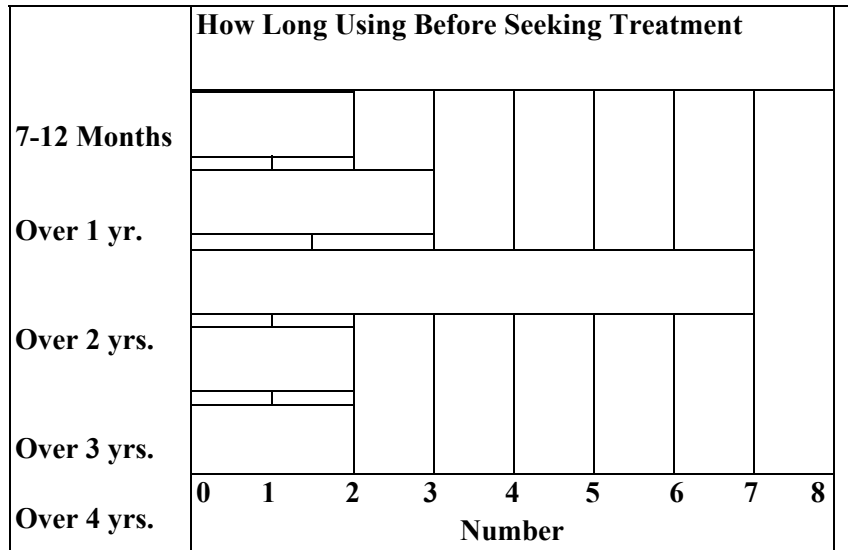
Of the 12 users who did not inject on their first engagement, ten went on to inject. Two people whose first contact was via smoking, were still smoking only when they came into treatment. Prior involvement with drug use was present for all sixteen.

Participants were asked to tick any of the following which they had used prior to their engagement with heroin:

- Alcohol
- Marijuana/hash/grass
- Ecstasy
- Amphetamines (Speed)
- Cocaine
- Tranquillisers (like Librium, Valium)
- Barbiturates (sleeping tablets) . LSD(Acid)
- Pain-killers, such as DF118.

Six people replied that they had tried all of the above before they tried heroin. Two more had tried all but one. Five had tried at least 5 of the above; three people had tried 3 of the above. One person only had tried only two, alcohol and cocaine, before trying heroin. In addition to the above list, participants also listed a range of prescription drugs ranging from tri-cyclic anti-depressants to narcotic analgesics. Physeptone was also listed. One participant wrote in the margins the additional information that the interval of time between her smoking and injecting was three weeks.

The responses to the query on how long s/he had been using heroin before seeking treatment were as follows:



Eight had been to medical treatment centres or GPs before becoming involved as a client with the agency where they were interviewed; 1 person had come from a work project for drug users. All 16 had tried to self-detoxify at some point. All were daily users, with amounts used before seeking formal treatment ranging from 1/4 of a gram to 1 and 1/4 grams per day with 6 people reporting 1 gram per day.⁸

When asked how they supported their habit, people reported multiple ways. In only one case did a person rely on one route only for funds to support a heroin habit. However, she also relied on her boyfriend’s dealing to keep her in supplies.

The responses were as follows:

Table 28: Age at Which Heroin was first Used

How Habit is Supported	Number
Stealing from non-family/houses/businesses	11
Shoplifting	11
Dealing	9
Using dole/rent allowance/child allowance	9
Stealing from family	8
Courier work	4
Formal paid work	3
Fraud	2
Prostitution	1
Mugging	1

Note: Total number of responses is > 16 due to multiple answers.

These patterns of activity to support their habit indicate the extent to which the family and local economies are impacted by heroin use. We did not inquire about criminal

⁸ Reports of drug-taking in surveys can be complicated by the issue of over and under-reporting. However, when, as in this case, the quantitative data is triangulated with data from the interviews themselves, there are internal checks on validity. This has also been the experience in recent drugs surveys in Northern Ireland. See G. McAteer (1992) Report on the Nature and Extent of Alcohol Abuse in the 12-17 Yr Old Age Group in West Belfast. BelfastFalls Community Council.

records as a result of these activities. But users most frequently targeted sources most likely to prosecute if they were apprehended, namely shops and businesses. Parker et al. (1988:100) argue that the heroin user has what they term an ‘exceptional criminal career’ as a result of her/his habit. With ‘normal delinquent careers’, the crimes and misdemeanours of anti-social youths settles down by late adolescence, often with no criminal record. However, their data from the Wirral emphasises that for those who become involved in heroin use, whether or not this use has been preceded by a rebellious or anti-social phase, criminal activity will emerge as a strong theme (ibid.: 100-103). The thieving, dealing and shoplifting which our participants have listed emphasises the fact that as Pearson (1988:117) describes it, the ‘commanding heights of the heroin economy’ exist between ‘two extremes of subsistence economies - farmers producing opium crops and street hustlers’. Pearson (ibid.) and Bourgois (1997:321) both note that the ‘retail sellers’ of drugs do so to finance their own habit; thus even in the best of weeks, they rarely earn more than they would in very low-paid work in the legitimate economy.

We have presented here data from a largely female sample. The activity of these Dublin women parallels the accounts collected by Taylor (1993) of women heroin users in Glasgow who supported themselves through shoplifting, theft, fraud, prostitution, dealing, and through using licit revenue, raised by depriving themselves of goods or selling off items. The use of children’s allowances etc. fall into the category of licit revenue; using those or the rent allowance ensures that a woman will face indebtedness and the burden of postponing the purchase of necessary items.

Of the sixteen participants, eight were currently unemployed; four were in receipt of a lone parent’s allowance; two were on a FAS scheme; one was in receipt of a DMPA. Only one person was employed.

Data on the school leaving age and educational status of participants is presented below:

Table 29: Age Left School

Age	Number
13 Yrs.	1
14 Yrs.	6
15 Yrs.	3
16 Yrs.	5
17 Yrs.	1
Total	16

**Table 30: Educational and Training Qualifications
(Highest Level Attained)**

Educational Status	Number
Group Cert	2
Junior Cert	6
FAS or other govt training	2
City and Guilds or other apprenticeship	2
No qualification	4
Total	16

Additionally, one participant who had completed the Group Certificate had later completed an English course while in prison.

The data from the questionnaires is sobering, representing as it does a group of people who have been under-resourced in educational and work terms and, as a result of their engagement with heroin, seriously marginalised. We now turn to their discussions of their lives as heroin users.

3.3 CONTEXT OF GROUP INTERVIEWS

In the literature, long-term heroin use has been identified or expressed as a ‘career’ with a discernible pattern which progresses through early stages of engagement to a complex way of life that includes and impacts on the economic, social and personal relations of each individual (see for example, Becker, 1963; Preble and Casey, 1969). Pearson (1988:29) has commented that direct accounts of heroin use in the early stages are rare because users in that initial phase do not see what they are doing as problematic. Thus they remain hidden from the researcher’s view, unless the latter is engaged in direct participant observation (for examples of this see Taylor, 1992 and Bourgois, 1997). The people we interviewed had all reached a point in their engagement with heroin use where they had sought treatment, either because the drug itself was problematic, or the way of life which accompanied its use had begun to create serious problems for them, or because of a combination of both these aspects. One was not necessarily split from another. This context-bound aspect of heroin use could and did create problems around appropriate treatment, as we shall see. People required help and support with the nature of their lives as drug users, not just with an addiction to heroin.

The data from these interviews is presented so as to express the chronology of people’s engagement with heroin use, how it began and how their lives became problematic as a result of their engagement. These categories represent recurring themes in the telling of people’s stories. The categories also endeavour to present the wide-ranging impact of long-term heroin use across many spheres of an individual’s life, including such aspects as family relations for a heroin user, supporting their habit, different forms of treatment, and the problems encountered in trying to move away from heroin.

Each of these changing contexts and pressures involved changing ‘vocabularies of motives’ (Mills, 1940:908). Actions which appeared reasonable in one frame of reference were interpreted differently as the complexity of users’ lives deepened. So, for example, although many accounts of initial engagement spoke of peer group involvement, at a later

point, people were inclined to state that using heroin had been solely their own responsibility. In a real sense, both versions are true. Young men and women took a personal decision to use but they frequently did so in the context of what Pearson terms a 'friendship network' where curiosity and acceptance of getting 'high', 'stoned' or 'wrecked' (Pearson, 1988: 18,25) was a shared language.

One thing is certain: heroin use, although a dominant and damaging part, is but one part of a person's life. The individuals whom we interviewed have grown up bearing multiple social roles which they carry out - young man or woman, heroin user, family member, parent, client of a treatment agency - which sometimes require them to act or express themselves in one way, sometimes another. For example, several interviewees brought their young babies or toddlers to the interviews and while relating their stories were at the same time doing exactly what the mother of any five month old baby or young toddler does, talking to their child, cuddling them, changing nappies competently. The researchers were constantly reminded of the potential and the energy people have to be all the other things they hope for, as well as being heroin users. One of the queries that follows on from that observation is how treatment agencies can be resourced to respond with comprehensive treatment packages that help people with their addiction by also helping to support people's total potential.

3.4 FIRST INVOLVEMENTS

From outside the sub-culture of heroin, perhaps it appears that pushers entice young people into drug use or that especially for women, first-time drug use may be foisted on them by male partners. These stereotypes do not emerge in the data collected for this project. With two exceptions, when interviewees encountered heroin for the first time, it was in a familiar every-day setting with other people who were either friends or family. Easy availability was a key element in all accounts of first contacts.

Many first contacts with the drug occurred within a social or recreational context, where drug mis-use was already an accepted feature of young people's lives and where getting 'wrecked' was part of their scene. Thus interviewees recounted that:

we used to just drink and smoke hash, and then we'd get an acid or something

I was sixteen when I started doing, I used to do hash and that. And I was nineteen before I got involved with heavy drugs, which was morphine

There was a big gang of us that used to hang around together and we always used to go around and we started doing ecstasy and all, but we done loads of stuff before that, and then we used to go to this dance every Saturday night, it was open from half eleven until half nine the next morning

I started off smoking hash when I was twelve. I was drinking say from about eleven, and I started smoking hash. And then I went sleeping tablets. Then I tried acid. We actually tried phy before we ever smoked heroin but like, it was just basically something to do .. we tried everything, you know what I mean, we were going to the raves. We'd try anything now, where drugs was concerned .. we were just fascinated with drugs. Like for the best buzz we could get, we'd just basically take anything, do you know?

I started only smoking heroin, like I was only smoking for three or four weeks, and I was saying to people, 'What do you get out of injecting?' And they were saying, 'You don't know what you're missing now.' So on me sixteenth birthday, I injected heroin and I thought the buzz was lovely, okay?

Well, when we used to go to ____, at that stage we weren't really drinking that much, we were more so into the Ecstasy, so we weren't into drink, but when we did drink, we drank a lot.

For three interviewees the context was somewhat different. There was a familiarity with heroin because they were either on the periphery of the lives of small-scale street pushers or actually working for them.

One young woman, while still only thirteen, was living with her uncle and his girlfriend, both addicts, who used to take her with them to shoplift. Through an acquaintance of theirs, a small-time street dealer with his own habit to support, she seized an opportunity to sample heroin:

It happened to me one night, I went into a flat and this bloke is dead now, but he was getting gear together, you know, bagging it like, he had it on a mirror. And he didn't want to give me gear because of the age I was and he knew me very well. But when he was finished with the mirror, I ended up getting the gear off the mirror, and I ended up snorting the gear

Another young woman had a similar opportunity:

I used to stay in a drug pusher's house, right, and the babysitter gave me a snort one night, and it made me real sick

A third interviewee was selling the drug at the age of fourteen:

I started selling, well, I started carrying heroin and doing drops of heroin. I just tried it one day in the jacks in MacDonalds, snorted it. I was only fourteen. I woke up at about one or two in the morning, someone beating down the door, 'Come on, we're closing.'

Two interviewees reported facing heavy pressure to take heroin, the first from her brother, the second from the boyfriend of the woman for whom she was babysitting:

He used to come in with his friend and his girlfriend every night and they'd be doing it in the kitchen. But like, I never told me ma that he was doing it or anything. But he asked me two or three times and I wouldn't put a needle in me arm. So he asked me again. And he done it for me. And I only skin-popped. And he mainlined me fella.

I was babysitting for ___ one night and she asked me to stay over, I was only eleven, and she asked me to stay, you know. So they all came in about three o'clock in the morning. They were after being out dancing on E. So she started taking out tinfoil, and I thought they were after taking hash out, or something. But they weren't, they were taking out heroin, and smoking it. And the fella says to me, 'Do you want some, do you want a line?' And I said, 'No, I wouldn't touch it, I don't know what it is, I'm only a child.' And then he said to the girl I was babysitting for, 'Well, if she's not taking it, get her out.' It was three o'clock in the morning and I was in ___ and where was I going to go? So I kept saying, 'No, no, I'll sit in the bedroom.' But I ended up taking it meself, no-one twisted me arm. I was pressured but I said no, then I gave in with meself.

This last account is a good example of how, retrospectively, the individual argues her own responsibility in opting to try heroin, albeit in a social context which made it difficult for her as a very young thirteen-year-old not to engage.

These first experiences could frequently make people feel quite ill:

So I went back and I was watching him doing the tinfoil, I hadn't a clue what he was doing, I'd never seen it before. So he started burning the tinfoil and put the heroin on it and he was there showing me how to smoke it, right. At first I thought it tasted like, here I was, 'That tastes like toffee or something,' but it made me get real sick, you know, I kept getting sick all the time. And then his sister came up and we had to hide it. So she gives me me dinner and the minute I looked at the dinner I just puked, do you know what I mean. And I just was lying on the bed, I was out of me head.

About a week later, I had a skin-pop of heroin. And like I was very sick on it, you know, I kept getting sick all the time.

One night all me friends were in a flat. As they were dying sick at the time, and I said to them, 'I'll buy you heroin if yiz let me smoke it with yiz.' And they were all, "No, no." And then I persuaded them. We were all round the same age, but they just didn't want me to get involved with it, over what was happening to them. But they gave in finally, because they needed it badly, so I got it. When I was finished, I said, 'What's this meant to do to you?' They said, 'Ah, you didn't do it right.' I said, 'Yiz told me to inhale it when I was smoking it and I'd get the buzz out of it, but nothing ever happened.' So we got another quarter then it all hit me at once. I was out of me head.

3.5 EARLY REGULAR USE

Pearson (1988:5) argues that heroin users exercise choices and decisions, which although they may later come to be regretted, are not experienced in the context of heroin being an instantly addictive drug. Thus Pearson concludes that heroin 'creeps into their lives by stealth, slowly and imperceptibly' (ibid.). Our interview data reveals a similar pattern. People, including very young people, vulnerable because of their age, take an active decision to engage in the early weeks and months thereafter. This pattern of early regular use takes different forms for different individuals:

I just snorted it for a few weeks and went home to me ma's, like I was away, I was after running away from home at that time. I went home to me ma's and I just thought I had a bad flu. It was the troubles I was going through but I just thought it was the flu.

I started only smoking heroin, like I was only smoking for three or four weeks, and I was saying to people, 'What do you get out of injecting?' And they were saying, 'You don't know what you're missing now.' So on me sixteenth birthday, I injected heroin and I thought the buzz was lovely, okay? After that first turn-on, I injected every day after that, because it was cheaper for me like.

One interviewee who had got her initial trial of heroin from a small retail pusher for whom she was baby-sitting, as indicated above, found the taste of it 'horrible' but found an opportunity to steal some heroin from this woman soon afterwards:

But one day she went to shop and she asked me to hold, like. Of course I robbed some of it. So, I met me brother one night.. and he said, 'There's this stuff you can buy for a tenner, and you get a lovely hit out of it.' And I said, 'Well I snorted that, it was horrible.' And he said, 'No you can use it by the needle, pop it, you know, skin-pop it. So I said, 'I have some of it.' So we went into a field and three of us used it and I wasn't sick at all, you know, on the skin-pop, where the snort of it left the taste on the back of me throat. I started skin-popping every night after that.

The young woman who had first taken heroin in the flat where she was baby-sitting stated:

So after that, I smoked it twice after that. When I was thirteen, I started smoking, coming down off E when I was fourteen. I was strung out. I'm eighteen.

A third young woman who first took heroin at her brother's behest, welcomed early regular use as a form of social identity:

I: And from that day, we took it the next day and the next day. Like, he had a few bob and he was getting it. We weren't getting it, he was.

Question: Did you ever enjoy it?

I: Ah yeah, at the start. I thought I was great, going around, 'Ah, I'm a junkie, I'm on heroin.'

One woman found a ready source of supply through a male friend who was a smalltime street seller:

It just came to a regular thing, you know what I mean? I just got addicted to it, I was going around every day, knocking for him. Like, he had money, you know what I mean. I used to say, 'What's the story, are you going down to get it?' And it was £40 for a quarter of gear at the time. And he'd say yeah. And he just used to go into the bank and give us a hundred pound, 'cause he had the money. And I'd be getting taxis everywhere and just getting the gear. You know what I mean? That's how I started, anyway.

A male interviewee, having convinced his friends to let him try heroin in their flat, attempted to regulate his early use, without success:

I just used to, started using it then every Saturday night. Then I went Friday, Saturday and Sunday. And then Monday and Wednesdays. Then before we knew it we were strung out.

A cumulative and increasing pattern of engagement was also evident in this account:

there was a bloke selling it [green physeptone] just up the road. We said, 'We'll go up and get (a cup) of it and see what that's like.'.. And me mate goes to me, 'Yeah, tomorrow night we'll get a ten bag'.. So we says yeah we'll do that. We couldn't even bum it ourselves, but we just said, yeah, we'll get that. It started off as a weekend thing, you know, say, Saturday night we'd only have a smoke. You know, we'd be looking forward to our smoke Saturday night. We were finished going to raves at that time. I was about fifteen. The ____ we used to go to, and that was shut down the summer, during the summer like when I was fifteen. And we started just "Ah we'll get a bit Friday. It progressed up to four nights a week, then five nights a week, and then we wanted it just every night, you know.

Heroin as a 'weekend thing' is an indication that people did not let go of their workaday routines. Two interviewees reported that they continued to hold down their jobs while using in the early stages while two more reported using while staying on in school. One of these accounts follows:

I was still in school. At the time when we were just doing it at the weekends, that was going on for about four months, just doing it every Saturday, and then we started doing it the whole weekend. It wasn't bad. Then about the seventh or eighth month we started, like, using it during the week. At this stage, I was doing me Junior Cert, but it didn't bother me, I passed it, lucky enough, but then I was glad I was out of school because I wasn't in the humour of getting woke up at half eight, 'Come on, get up for school.' And you had to sit in the class, dying sick.

Heroin use does not necessarily lead to an immediate disengagement from the 'normal' world. The reality is that young people can work or attend school while using heroin and do so undetected. This raises searching questions about the type of prevention programmes which might have an impact in these early stages.

3.6 THE SOCIAL SETTINGS OF HEROIN USE

With the exception of the interviewee who first took heroin in a MacDonald's toilet, these accounts point to heroin use in a variety of domestic settings, often where very young people were in an opportune position to experiment with drugs because of their availability through young adults who were also using and/or selling. Drug use as part of one type of youth culture is especially clear in the last two accounts above: one, where a group of young people were in a private flat (and where they actually tried to discourage the interviewee from getting involved); the second, where two young women who built up a social life around smoking heroin assisted by the ready availability of supplies close by

their own homes. The well-known club where they had gone for raves, had already introduced them to a setting where people took Ecstasy for the duration of a night's dancing and then smoked to come down the following morning.

This aspect of youth culture in Dublin adds another layer of explanation to that put forward by some interviewees about the concrete problems of social exclusion that already confront young people in many areas of Dublin. It is absolutely true that for these young people, there is a bleak future:

I mean, where I live there's a hundred and five flats. There's just three blocks of flats. There's no amenities, no facilities. There's no kids club. You know, there's absolutely nothing. There's not even a tree, never mind a green area.

When you get bored, it's all right to go in and have a game of snooker, but I'd say you'd get bored with that after a few months as well. I have to say the highlight around this area is the robbed car. When there's a robbed car everyone comes and looks and it's like watching something on the telly, it's great.

I mean statistics show that's where the most drug abuse is coming from. That's where the most problems are, you know so it can't be ignored anymore. It has to be recognised it's breeding, this is what's happening. This is what's happening to our young people, and it's not our fault.

I really can see how so many kids are getting involved in it. And it usually, I mean, I don't mean to categorise, but it usually is people who come, who are unemployed, and don't have much money, and they're so pissed off they take that road.

'Cause we went from FAS scheme to FAS scheme, looking for work, and they just put your name down, and they'd say that they'd get in touch with you. So we just got fed up with it.

As indicated by the statistics derived from the prevalence survey carried out by the research team, residents from Dublin 1 predominated in the lists of three of the five treatment and support agencies while residents from Dublin 1, 7, and 8 combined predominated in all five clinics. This provides solid evidence about the widening impact of heroin use in inner city areas which have already endured decades of economic neglect and where it is a common experience to remain excluded from prosperity and decent employment opportunities.

However, interviewees did not argue that all young people in these localities are equally at risk from heroin:

I think it's who you're with as well, that has a lot to do with it, getting mixed up in it. I mean my brother is with a, all his friends, none of them touch anything, so therefore like there's more of a chance that he won't go near it. But whereas who I was with, everybody was into it. You know?

Thus there may be critical differences in the lifestyles adopted by young people and what role drug use does or does not play in those lifestyles. Moreover, a lifestyle itself may be linked to a search for a different identity, as in the account above, where the interviewee saw herself as having the status of a 'junkie'. Even without being that explicit, there is evidence in our data of young people seeking a different way of life to ordinary routines which are leading nowhere. In the marginalised setting of the inner city, where their futures offer very little, where their everyday lives are routine encounters with school structures out of step and largely irrelevant with where they are, their energy becomes focused on alternatives:

You get up in the morning, have your breakfast, go out to school, get homework, and you might do it and you mightn't. Then you get your dinner and then you go out, then come back in, go to bed, and you're back to the same routine. With me, I just wanted to experience something different, and it just got out of hand, really.

I didn't really know what heroin was at first. I raved for years for years and years, I raved in England first, and I knew people used to take something to bring them down off E, but I never really knew much about it. Then me ma and da separated when I was about seventeen, and I moved into a flat. And people that I used to go raving with used to come up to the flat, and we used to have turn-ons in the flat. But I still wasn't into it then. But then one night they kept at me so in the end I done it. Then I was doing it every night. Then all of a sudden I had no money. I woke up about three months later and I was sick, I was all strung out, you know.

The reference in this last account to using Ecstasy and then heroin 'to bring them down' appears to have been one part of the picture in an initial involvement with heroin in the early 1990s in Dublin. This period saw a very local dance scene develop in a number of different clubs in centre city Dublin which were cheap to get into and where Ecstasy was available. Heroin was also widely available without hindrance. Several of our interviewees recounted that they had attended one club (which was closed down in the mid-1990's) where the sequence of taking Ecstasy to dance for the night and then smoking heroin to bring oneself down was a central feature.

This suggests that the local dance culture at that time, combined with easily available heroin, may have swung the balance in favour of heroin use for at least some young people. But youth culture is synonymous above all with rapidly changing fashions. Moreover, experimentation with certain sorts of drugs may be as heavily dependent on issues of supply as on issues of fashion. Thus what patterns there were, when our interviewees were first being introduced to heroin will not necessarily hold true at this point. But it may be useful to point out that this pattern did crop up elsewhere. A 1995 survey in North-west England, centred on Manchester, found a higher level of heroin use amongst young people than the national reported average in England and Wales at that time and it is suggested that this may have reflected not just economically disadvantaged areas, but also Manchester's prominent dance club scene (Shiner and Newburn, 1997: 514,517). This point is also taken up by Collin (1997) whose work on the 'chemical generation' indicates the expertise young people participating in dance culture sought to develop in handling sophisticated but potentially lethal drug cocktails, the combinations and quality of which were not controllable and about which there was almost no reliable scientific data as to short-term and long-term effects. The stumbling block in establishing hard data, Collin contends, is the dividing line between illegal and legal drugs. The former, being neither tested nor licensed, are not uniformly quantifiable as to the outcomes they produce.

As for patterns of consumption and local variants within general patterns, there is again only patchy data. A recent Scottish study on prevalence of drug use among schoolchildren between the ages of 11 and 16 indicated that about one third of them had used an illegal drug and the majority had consumed alcohol. The age factor was highly correlated with use of drugs, with older children being more likely to have tried an illegal drug (Barnard et al, 1996:81). The most recent Irish data available cites a figure of 53% of young people who reported ever having tried an illegal drug (National Youth Council, 1998)

We need wide-ranging data to make sense of locally high rates of different types of drug participation compared with national averages, which interrogate how youth cultures develop distinctive patterns in disadvantaged areas and what the links are between these developments and locally available supplies of drugs. It is evident, for example, that in local authority housing estates in Cork which are as marginalised as inner city Dublin in

socio-economic terms, heroin is not the drug of choice - nor is it generally supplied in the area (Jackson, 1997; Personal communication, Marie O'Shea). The interplay between drugs and policing policies, suppliers, availability at street level, and even local community action and how these factors translate into higher or lower rates of heroin use are too little understood at present.

What is clear from this study is that young people in inner city Dublin have multiple opportunities to become knowledgeable about drugs and their familiarity with how to access and self-administer various drug types becomes part of their self-image as well as something they can make available to others:

All me friends started smoking heroin and a fella used to sell phy tablets, so I asked to give us two one night, and see what it was like. I done it and I liked it, but then they went off the market, you couldn't get them.

How did it happen? 'Cause I was going out with me fella, and then, like he was a lot older than me, he was thirty-three, and I was twenty, twenty-one or something, and he just says to me, 'Did you ever smoke heroin?' And I says, 'No, what is it?' And he goes, 'We'll go back to the gaff and we'll have a smoke.' And I says, 'Yeah,' I says, 'But what does it do for you, like, you know?' He says, 'Ah, you'll be nice and relaxed.'

Thus even where parents intervened early on to stem drug mis-use, the young person experienced such interventions as an attempt to undermine her own sense of what she was:

I was thirteen the first time I ever attended here, and me ma and da came with me. It was 'cause I was caught smoking hash in school. I wouldn't come, like, they literally had to drag me here. I thought it was all crap, you know, 'I know what I'm doing, I'm not going to end up on this, like.' Like, people said to me, 'You know smoking hash, that's the first step you can take, 'cause it's going to lead on to other things'. 'No it's not!' ..But I know now that it fucking does. Like, nine out of ten times, it will, 'cause most people I know they're all smoking it now. Most people that I would have hung around with while I was smoking hash, going out drinking you know, they're all the same.

Severe family problems were a factor in heroin use for two interviewees:

Like I realised you don't just go onto heroin for nothing. There's always something in your past somewhere. When I was off heroin, sometimes you'd use something else as a substitute. And I was doing great, working and all, but then I turned to drink. I used the drink as a substitute, which was worse again.

My experience of it is something bad happened to me personally when I was fourteen, thirteen, and at that time I just wanted to just fucking die. So I started taking valium. Then I took heroin. I od'd [overdosed] the first time when I started with heroin. Like a snort. But I still turned back to it again, you know, on the needle, but I liked the needle better.

But family and personal problems are by no means always the major factor. The data we have collected also suggests that heroin use is more immediately bound up with how young people develop a pattern of socialising:

There wasn't any real, there wasn't any family problems or anything, like I wasn't really getting on with me ma. I was living in ___ with me nanny but, well I'd say it could have been from that, but we were just real adventurous, you know what I mean, just we were into everything, you know. That's basically it, I think, you know

I don't think even a lot of us know why we started, it's out of pure, just curiosity, you know the thing like when you're young, you're a girl, I won't get pregnant, it happens to other people. And I think that drug users have the same attitude, you know?. It's like when you're young, you're invincible, you know, and you won't get addicted, you don't think you're going to get addicted.

Official campaigns in schools etc. do not appear to take into account the strength and importance of experimentation for a youth sub-culture that helps to define young people's lives:

You feel left out if you don't do the things that your pals are into. You know the way they [parents and schools] say, 'Ah you have to learn to say no.' Nobody's going to say no if they're going to feel out of it.

One of our interviewees had been using heroin for a 25-year period and he commented on a rapidly expanding and organised market for drugs throughout the 1980s and 1990s. Whereas breaking into a chemist's shop or stealing a doctor's bag were the modus operandi at the beginning of the 1980s,

Later on then .. it started coming from England, Iran, everywhere. All around the world. And it was much more available, then it was easier to be dealing in it, and so on, you know, because there was so much of it around, you know.

A second older interviewee commented:

But it seems to be getting worse. It's everywhere you go. Everyone is stoned out of their heads, you know.

The increase in consumption appears to be fuelled by a volatile combination for many young people of availability; a changing and expansive sub-culture which rates being 'stoned' or 'wrecked' high in importance; and the economics of heroin which has made it far cheaper over the past twenty-five years. All of this is set in the context of a bleak socio-economic outlook for inner city communities.

Thus an older male interviewee argued:

Well, like, I'm at it a quarter of a century, so I mean, I go right back to where it kind of began. You know, when the figures were very small. I can remember a headline in the paper saying they were really worried about the number of addicts in Dublin because it's increased fifty per cent from the year before. And the year before, there was ten. And then this particular year, which is around '73, there were twenty one addicts. Now today, there's ten thousand addicts.

The deepening structural crisis for inner city Dublin and working-class communities on the periphery related to deindustrialisation has left room for the illegal heroin economy to flourish. But even if a career as a heroin addict has offered young people an alternative route to identity as well as a resistance to the mainstream culture which has rejected them, heroin users ultimately pay a very heavy price for this form of resistance.

3.7 SUPPLY ISSUES AND SUPPORTING A HABIT

Ethnographic accounts of heroin users consistently report the extent to which an individual's life is structured around activities which prioritise the drug. The daily user especially is dominated by the issue of raising the funds to pay for heroin and then to source the drug; actually using the drug takes up a very small portion of the day (see for example, Hanson et al. 1985; Johnson et al., 1985, Pearson, 1988, Taylor, 1993, Grapendaal, 1995, Bourgois, 1997). This concerted activity is precisely what Preble and Casey (1969) targeted in their classic article "Taking Care of Business". They wrote that 'the cost of heroin is so high and the quality so poor that the street user must become totally involved in an economic career.' (Preble and Casey, 1969:2).

It is disconcerting that this observation was made almost thirty years ago; since that time, the problems of quality have intensified dramatically, although relatively, the price of the

drug has fallen with increasing competition. Older users amongst our interviewees expressed concern at the increasing lack of safety for younger people because of how the drug is cut for street consumption. It was argued that Ireland is now known as the “rubbish bin” of Europe, with dealers importing and then cutting the worst quality of drugs available on this illegal market:

And whatever is going, you'll take. You'll go up and you could get ripped off. You could get dirt. You know, there's loads of problems now, everything.

The fact that the trade remains entirely outside the law presents a number of other dangers and threats for the user. S/he, in order to raise money for heroin, commodifies every possible facet of living in order to raise funds for the drug. This is the meaning behind the figures presented above on the activities through which people support their habit.

The drug itself presents a major opportunity to fund one's habit by becoming a small dealer:

I mean most people, I mean, there's dealing and dealing. I mean most of us here would have dealt a little bit because you have to support. But I mean you'd sell to people you know, and you'd have your little bit for yourself and that's the way you do it. But then there's big dealers who, you know the big dealers who have all the money, they don't use.

Selling also provided a sense of economic independence :

We used to sell in town, so it was handy enough doing that, 'cause any money I was getting was me own. No one knew that I was selling in town really. If something was getting sold by someone, I'd make a few quid on that, or else go in and shoplift meself.

A personal relationship with a small street dealer was another way to guarantee supplies:

And I was going out with me fella at the time. I started going out with him, I'd say it was, I was fifteen, I was a bit over fifteen like. He was more into the coke, but he was selling gear and that so there was always something there for me. I didn't really have a really hard time.

Bourgeois (1997:280) argues that policymakers have still not taken on board the relevance in inner city culture of drug-selling by addicts. All psycho-active agents are incorporated into the street market, including methadone (as we saw above, where green physeptone was on sale at the local corner). The heroin user of necessity becomes as adept as any retail chemist, in sourcing in bulk, pricing and selling on a variety of prescription drugs:

But when I was taking it [heroin] during the day, I was dealing other tablets, tangeegees and DFs, morphine tablets and that was like supporting me heroin habit, okay. Now, like, I'd sell me tablets which I was getting for little or nothing, like buying in bulk, I was getting them for little or nothing. And that would support me heroin habit. But like, at the starting of the day, the first thing on me mind would kind of be, 'I'll have a turn-on today.' I was getting the morphine tablets very cheap. When I was selling them, sometimes they were seven pounds a go. Now when I was buying them in cards, I was getting them for about £1.50, £2 each. So in other words, I was making a fiver on each one I sold. And DFs, if I was buying them in bulk, I'd get them for cheap. Just like say, a friend of a friend would say, 'I know a person, he sells tablets for little or nothing.' So I made an agreement with him, 'Every time you get your script, I'll take the lot off you in bulk.' Which is better for him. So I'd give him the money and he'd give me all the tablets. And then I'd start getting me heroin, and then sometimes I wouldn't have the money, like for £40 so I started getting into naps tablets for cancer, people that have cancer.

Both this interviewee and the one below reported similar adjustments when the expense of heroin and the shortage of cash led to the use of other cheaper narcotic agents. This also led to a variation of daily intake:

For smoking heroin I was spending £120 to £180 a day, just for smoking. And like, I smoked for so long, when I couldn't afford it, I went onto naps they were £20, £25.

A number of questions are raised from accounts like these. The questionnaire data from the entire group of interviewees indicated a very low level of formal educational attainment. Yet within the illegal heroin economy, these users learned to work on a daily basis, to calculate profit margins, and to negotiate working relations in order to make deals. When Bourgois (1997:320) argues that it is a vital political task 'to alter the imbalance between the illegal drugs economy and the legitimate economy at the levels where people are being allowed to participate', this is precisely what he is referring to: the fact of the matter is that illegal street dealing is as close as thousands of young people have come to having 'real work'. This is why Bourgois characterises the retail sales network for narcotics as an "equal opportunity employer". The crucial issue for young drug addicts is whether this range of unquestionable skills they have developed can be legitimated. But this is bound up in turn with the equally crucial issue of whether or not there is actually going to be a place for the marginalised young person from the inner city in an economy which may have already have determined that their labour is completely expendable. One further aspect to this complex equation of the heroin economy is the way these 'jobs' are an 'activity which soaks up energy and ambition that cannot be absorbed elsewhere' (Bourgois, 1997: 321).

However, not all our interviewees dealt in drugs to support their habit. One interviewee held down a job to support her habit:

I could still manage to support meself on gear because, the way it was, there was four of us having a smoke. There was me three friends, they were brothers and sisters, one brother and two sisters, like. They only live across the road from me. And there was me, and the four of us were working. And we wouldn't have a penny left at the end of the week for anything, we'd just have the money, our housekeeping money, like I'd give me nanny more money for housekeeping. And we'd just pump the rest into gear 'cause with four of us, it was a fairly alright job like. Minimum wage, like it wasn't crappy money, so we just survived through that.

But the underlying issue is the same for this woman - the problem of minimum wage, less-skilled work which leaves the individual with poor prospects for the future, more especially when s/he is implicated in heroin use.

Another vital aspect to securing one's supply is learning how to distinguish a reliable dealer from a less reliable one. There is also the matter of how far a person is prepared to travel to find a supply:

When I first started on heroin, we were a bit iffy about 'Oh, what if we go over to that fella and he rips us off,' and all that. That was the first time, and we were there for about a half an hour waiting to get it, and then we just said, 'If he rips us off, we'll just kill him and that'll be the end of it..Cause you just used to have to walk out, down to the corner down there and everyone would be out, it would be like a supermarket, see who has the best gear. That was for the first few years and then it started dying down here, and all the vigilantes came and thrun them all out. We used to have to then travel far for it, but I was never one that was into travelling. The furthest I'd go is O'Connell Street, that's it, and I wouldn't go any further. I went out to Ballyfermot meself a few times, but its too long of a journey when you're not in the humour for it.

One interviewee reported that scarcity of heroin of smokeable quality during a ‘drought’ had led to her injecting:

I really started getting into using while I was waiting on the clinic for about three weeks there was a drought on and you couldn’t get anything anywhere, and like the bit you could get only probably get eight or nine lines out of it, so you’d use it and you’d be grand for a while, a lot longer, you know, than just smoking it. So I was using while I was waiting and I got a phone call one Tuesday to say I was to go down.

This same interviewee described her relief, when she finally began treatment, at being able to abandon this stress of the cycle of work in order to score, combined with the impact of the drug on her physiologically:

Like when they started me I gave the counsellor a thank-you card, because the way I looked at it was, I won’t have to get up in the morning shaking and sick, I won’t have to go out shoplifting. Then, when you get your shoplift, then you have to sell your clothes, then you have to go and get your gear, do it up and then put it into you. So I says, “No, I don’t need that life any more.”

3.8 HEROIN GOOD AND BAD

That last extract indicates that heroin turns bad for people, turns into shaking and sickness. But heroin, like all other intoxicants, including alcohol, is contradictory in its effects.

Irvine Welsh’s book, *Trainspotting*, and the subsequent film aroused controversy with its portrayal of heroin as ‘good’. Such lines as ‘What they forget is the pleasure of it. Otherwise we wouldn’t do it’ distressed many people working in the field of drugs education who argued that young people might be adversely influenced by an image of heroin that is enjoyable. This is a challenging aspect for those working in the fields of prevention and treatment alike because of the contradictions inherent in engaging with the drug.

Despite the common experience of feeling ill on heroin the first time, interviewees also reported its use as pleasurable. The effects may not be the same for one person, compared with another, but the vocabulary used to describe its impact is similar - ‘lovely’, a “buzz”, ‘relaxed’, ‘taking away everything’, ‘no worries’:

Well, it’s really too hard to explain the buzz that you got out of it. It just made you feel relaxed, and you had no worries and it was good being able to lie there and not worry, or have a care in the world. Then when you start coming down off it you start worrying, ‘Oh, what if I go in and me ma looks at me eyes and she sees they’re all glazy? And this and that.

But a girl that I know that I used to go in shop-lifting for, her boyfriend went to score gear for us, and when he came back, the gear that he was after getting, like you couldn’t skin pop this gear, you had to mainline it. So this was my first time to mainline gear. But when I did get it like, I felt sick, but yet I felt it was lovely, you know. Like and that started me off on drugs, you know. The feeling, as soon as he put the heroin in to me, like I could feel it straight away and it was a lovely feeling.

The needle took everything away. At the time, like, it was really good heroin, it was lovely, it was. And the first time for me, I od’ed, went into hospital, but I still went back to it. I tried the needle, and I found it blocked all me problems. So I stayed on it then.

There are contradictions even within these accounts: how can a ‘buzz’ also make you feel ‘relaxed’? How can being ‘stoned’ and ‘wrecked’ (see accounts above) be described as pleasurable? To reach this point may entail what Pearson (1988: 24) terms ‘powerful

lessons' about intoxicants, from which people "learn how to take the drug properly, how to handle its effects and interpret them as enjoyable' (ibid.). However unclear and imprecise the language used to describe this enjoyment is, it is important for policymakers to bear it in mind, because it presents a core reality of people's experiences with heroin, as with this interviewee:

So it is fun for a while, I mean I can't say that I didn't have fun, because I did enjoy a lot of it, and I enjoyed the drug.

If this is denied, intervention strategies for prevention and treatment alike will fail because they will be perceived by young people to be working from the wrong or even deliberately dishonest premise. The terrible irony of heroin is that people experience it as both good and bad.

It is also important to bear in mind that the levels of competence young people gain in how to use heroin and how to interpret it arise from extensive drug use of all types, as the questionnaire data reveals. And as people become more experienced, they may seek different sorts of sensations. The immediate rush that is obtained from injecting rather than smoking is often a critical cross-over point in this search:

But when you're starting using you think it's great that you get such a stone out of such a bit of gear, like, and you wonder why you smoked gear and you're going, 'Ah, I'm after being wasting me time smoking it, look at this little bit!'

Despite a similarity of language to describe the impact, young people perceive distinctive differences between drugs, for example, between Ecstasy and heroin.

Ecstasy is just a real hyper buzz, you don't want any trouble or, you just want to be real laid back about everything, and you don't have a problem in the world. With heroin, for me and for a few other people, you don't, when you're on it you let all your problems go, but with ecstasy you're all hyper. On heroin, you just want to lie there and not be disturbed, 'cause you're enjoying it so much.

One interviewee even cited heroin as a more grounding drug experience than Ecstasy:

Do you know when you're finished and your head is still up in the clouds, well, all my mates, you know, they take tablets and all to come down. Well, it was about five months after I stopped taking E, about five months, that I touched the gear, and for about five months me head was all over the place, I didn't know what I was doing, and the second I touched that gear I came straight back down to reality, it was mad it was.

The realities change, however, not least because the further in people get with heroin, the more difficult all their social relations become. Accounts like these, where interviewees fell out with fellow users who were stealing their drugs on them, were common:

And I was after splitting up with the fella that I started going with, because things weren't working out, you know, where gear was concerned. He was hiding gear on me, and I was hiding it on him. And he'd be giving me vinegar in a works and I'd say, 'Put it back on the bleeding spoon, you didn't fucking, that's not gear.'

Like, at the start we wouldn't do it without any of us not being there, but as it went on, once you had the money or someone else had the money, you just wanted to get it without sharing it with anyone else.

And even before you got your gear, if someone was gone out to get it, say (Name) was after going out to Ballyfermot, he was on his way out there to get it, we'd be all sitting in the room and we'd be fucking literally killing one another, you know what I mean, 'cause we'd be in such bad form, we'd

want to, and there'd be murder in the gaff, you know, it was gas, it was, so stupid when you look at it, like, it doesn't feel stupid then, but it is now, when you think of what you're fighting over

Prolonged use of the drug and the circumstances that accompany its use brings people into profound dis-ease with themselves:

Like if you come down off drugs and you're back out into the street, well you're back into reality, you know. So, your self-esteem is low, your confidence is down, and everything else, you know.

Nevertheless, the hold on people's emotions and psyche that the drug has is strong:

If you're after being off heroin and you're sitting in a room with everyone doing heroin and they offer it, you're going to take it.

It is of critical importance in developing relevant treatment programmes to remain aware of the 'real ebb and flow of a damaging but nevertheless pleasurable relationship to the drug' (Pearson, 1988:30) in all its contradictory aspects. The end effects on each heroin user's life are highly individual and, as with any chemical substance, there is no precise or predictable relationship between that and human reactions (Murphy, 1996:23). This wide range of possible reactions and relationships to heroin creates huge dilemmas in responding with appropriate treatment regimes.

3.9 WHEN HEROIN USE BECOMES PROBLEMATIC

Not all people who try heroin go on to suffer addiction. Some disengage almost at once; some because the lifestyle that accompanies its use is unwelcome (Pearson, 1988: 83-84). Unfortunately for all our interviewees, at some point in their lives, heroin became difficult for all of them. They began to lead a 'self-destructive daily life' (Bourgois, 1997:34):

I don't know how much heroin I was using a day, 'cause I was selling it. And anything I was selling, you know the way you get 12 Qs for yourself. I don't know how much I was using, I was just fucking using everything I could get me hands on.

The first indication for some that they had moved into an addictive state with the drug was the first time they experienced withdrawal:

I didn't realise I was strung out. For three or four months solid, I was injecting everyday, okay? Now, one day I hadn't got anything, right? I thought I was getting a flu, only for someone told me, 'You're strung out, you're dying sick.' I'd have never known. Know what I mean?

The first time I went through the sickness I was in a bad way, and I just thought, I was getting pains in me legs, and I thought I was after pulling a muscle or something, 'cause I used to do courier working. I thought I was after pulling a muscle, so I said, ah I'll just take it easy for a few days. I got told that I was addicted to heroin by friends, 'cause we all done it at the same time.

And we got strung out not very quickly. It took a long time, 'cause a lot of us were working, you know, we weren't running around all day. It was just a night-time thing. I left school. It was just a night-time thing. When it started progressing into it when we were really, I took an overdose then. It wasn't on gear, it was just on anything, just a load of tablets, painkillers and stuff like, because I was strung out, you know, I was sick one night, it was me first night ever going sick without it. It was the first time I really realised, 'Jaysus, I'm in head deep in this'.. And I was real depressed about it that night and I took an overdose.

One interviewee who had relied on her boyfriend to supply her, broke up with him over heroin and then found that she would need ways to supply herself, other than her wages:

I was coming to the end of me last week in work, I knew this fella that was selling, he gives you gear to sell, so I went down to him and I got gear and started selling it. I was caught goofing in work, the last week and I was up at the table in the room like that. And I kept saying, 'I'm awake all night, I'm out partying.' Out of me head I was. And the teacher wasn't in and I had to take the whole class, and I let them fucking wreck the class, 'cause I was just stoned sitting there. And one of them (teachers] walked in and caught me.

Heroin becomes problematic when you must take it to feel alright:

I didn't realise that I was strung out, until when I hadn't got it and someone turns around and says to me, I said I think I'm getting the flu, and he says had you got anything today, and I said no, you're dying sick, he said, you're strung out to bits. And I just copped on, Jesus Christ, you know what I mean. So the minute I got something into me, I was okay. In other words, to keep me okay for the day, I had to have a turn-on. You know what I mean like, the feeling, when you're withdrawing and you're going out to score, you'd be sweating and getting pains in your legs.

Not only does a person need heroin daily but s/he needs the funds to purchase often increasing amounts:

When it starts becoming a problem, it's wow, a big problem, it really is. It's not the drug that's the problem, it's life becomes a problem when you're using drugs, because you have to get money .. when you're left with a big habit, like you need say four hundred mis a day, what do you do? There's nowhere you can go to get that amount.

Apart from the economics of addiction, there comes a gradual realisation of what addiction means:

When you're on heroin, right? And then you finally realise yourself that you're strung out, you blame everyone but yourself. You blame everyone for getting you strung out, but yourself. You blame your family, you blame friends. You blame everybody, but you don't blame yourself. But sooner or later, you realise that it's your own fault and no one else's.

One interviewee, who had a serious congenital heart defect, faced the bleak truth of her addiction only after doctors confronted her with a decision to have a Caesarean to deliver her very premature baby, in order to carry out an emergency operation on her heart a second time.

And she (the doctor] said, 'One of your valves, you've four valves around the heart, the one on the right side of you is rotten,' she said, 'from using the drugs, all different kind of drugs.' She said, 'There's an awful lot of dirt on it,' and she says, 'What we're afraid of if any of the dirt flies off the valve.'

Her baby's father was in prison at the time of her baby's birth. The baby weighed three pounds and was in intensive care for some months. The father of the child died a week after its birth.

The interviewee who had taken an overdose when she realised her state was taken into hospital as a result of her suicide attempt. Despite her experiences however, she was back using heroin in a relatively short time. And, this time, she made the shift to injecting:

I was eighteen then, I think it was April, I was sick one day and I was, like sick from gear, I hadn't had gear that night. I was really bad, right, I wouldn't go into work like, I started missing days in work. Like I'd have, not much but like at least one day every two weeks like I just wouldn't go in, like and

I'd come up with every illness in the book. Me boss was saying, 'What's it this week?' You know, it came to the stage like they even copped on to what was happening, you know, so one day I was lying in bed and I was in bits, and I says, 'I can't go on with this, like, it's hurting too many people and meself.' Like, 'look at the state of you. What way are you, you're going to be dead in two years.' I was after starting to inject, you know. So I got up out of the bed. I just got on the bus and I went down to me own doctor, me own GP in ___ Street.

These are stark moments: a suicide attempt, a life-threatening condition arising from heroin use which also threatens a baby; a very public exposure in work of one's addiction; a commitment in all these accounts to a stressful daily routine of funding and finding the drug. Thus there is a vivid sense in which these moments of self-recognition about addiction emerge out of a period when people have actively deluded themselves about their relationship with the drug.

Grapendaal et al. (1995:60) in their study of drug users in Amsterdam argue that the changeover from controlled occasional use to virtually daily use of heroin was 'accompanied by denial, self-delusion, and sometimes extreme naivete'. Pearson (1988:83) argues that users and former users present their accounts retrospectively of their conscious choices and decisions around sustained regular use, as if they were passively caught up in a 'relentless pharmacological process': 'they rarely embrace any recognition of their own motivation and agency' (ibid.).

What is striking about the accounts from our interviewees is that their drug use has taken place in a setting where the results of addiction are readily seen. For young people now, in Dublin's inner city, there is no shortage of examples or experiences about what the endgame with heroin entails. The widespread nature of heroin use however, sends out two signals simultaneously: the drug culture is one way of life among several in the inner city and to that extent 'normal'; it is also a dangerous way of life.

This intertwined information suggests that what needs to be discussed is, in the first instance, the problem of getting across a credible message about heroin use that makes sense to young people who are experienced about intoxicants and eager to experiment; secondly, what sort of local support services can appear credible enough to young people to encourage them to move away from heroin before regular daily use sets in. These problems are similar to those faced by professionals working in the field of safe sex, where in efforts to reduce the numbers of crisis pregnancies and/or to reduce the risk of transmission of HIV, a series of accurate and meaningful messages have to be got across about the risks which make sense and which overcome the invincible feeling of young people that this always 'happens to someone else, not to me' (see for example, Aggleton and Homans, 1988; Hyde, 1996).

3.10 SEEKING TREATMENT

The period of time which elapsed until they identified for themselves their state of addiction ranged from months to years. This discovery or admission was not necessarily followed up with first attempts at treatment. Indeed it often followed by an intensified use of heroin. But either at this point or at some other point, shifts in family relations, social relations, weariness with the way of life addiction involves, or life crises, such as those described above, can bring people in to treatment. There are 13 programmes in total available from the five agencies which participated in the prevalence study and from where interviewees were selected. They include needle exchange programmes, methadone

maintenance or stabilisation programmes, detox programmes, special smokers' clinics, residential detox programmes, counselling, and work programmes. This range reflects efforts on the part of statutory and voluntary agencies to offer services to the heroin user, whatever stage s/he has reached with the drug. Figures on the waiting lists from the prevalence studies indicate that the two most sought after programmes are the stabilisation and residential programmes. However, despite this effort to match user and programme, the value of treatment programmes remains controversial. This is related to two different and hotly debated treatment philosophies: whether treatment should aim to cure the addiction entirely or whether treatment approaches should accept that the drug plays an important role in a person's life and therefore enable the drug user to reduce the risks associated with its use. This latter model of harm reduction became a key part of Dutch drug policy, from 1976 onwards, anchored by the argument that a health policy which excluded from assistance people who were unable to overcome their habit or did not see the need to throw off their habit was completely ineffective (Grapendaal, 1995: 11-12). This was an attempt, in other words, to begin to incorporate the social dimensions of a user's life into treatment policies and to take on board the fact that heroin use occurs in variety of social contexts. Grapendaal et al. (1995: 12) argue that upwards of 73 per cent of the local drug user population in Amsterdam have availed of this model of treatment, combining methadone maintenance, casework and some psychomedical therapy.

A harm reduction model has gradually gained ground in Irish policies during the 1990s but there appear to remain strong differences of approach and outlook between different agencies. Some, for example, are low-threshold agencies where the heroin user is offered counselling and support in response to her/his own terms of reference. Other agencies, offering methadone maintenance, screen clients using regular urine tests. Consecutive failure to produce clean urine may result in a client being removed from gradually reducing methadone programmes to programmes where all that is offered is a maintenance dose of methadone, for example. Even for low-threshold agencies, where work and re-training programmes are often run, clients really need to be stable, either on a maintenance or detox programme in order to gain full value from re-training.

Entry requirements and strict screening criteria for programmes can reflect the fact that agencies must take rational decisions around limited resources. They may also reflect, however, different medical treatment philosophies. Beshner and Walters (1985:157) argue that from the beginning of the twentieth century, when heroin as a drug began to be considered a dangerous addiction, there are three principal issues, recently joined by a fourth, which have dominated treatment debates:

- whether addiction is a disease or a crime;
- whether heroin maintenance should be provided;
- whether other pharmacological agents should be used in treatment or treatment should be entirely drug-free;
- whether clients on methadone maintenance should be detoxified from methadone after a limited period or be allowed to remain on the drug indefinitely.

These debates are alive and well in the Irish context from the position of policymakers and service providers in ways which can be detrimental to users. Thus they also come through what heroin users themselves have to say. Their treatment needs change because these are dependent on changing decisions about other aspects of users' lives. The problem for users

is that policies reflecting one or another aspect of these debates have often resulted in a lack of reflexivity on the part of available services and an insufficient breadth of services.

The Recommendations from the 1997 Ministerial Task Force on Measures to Reduce the Demand for Drug have called for an expansion of more socially-based dimensions to treatment and support, including on-going rehabilitation.

Pearson (1988), in his ethnography, points to the wide variation of decision-making of users around ways to tackle coming off heroin. Some people may feel it is easier to do it slowly, some all at once; some by doing a self-detox. Much is dependent on the immediate motivation for trying to kick the habit. The young woman who took an overdose on admitting to herself that she was an addict, went through the worst of withdrawal while in hospital, but within months had returned to heroin:

I was in hospital for a week or two and I was off the gear then for about four months, and I got straight back into it. You know what I mean? I didn't do a detox. I just went cold turkey in hospital. You know what I mean? I got back into it then, and I'd run out then on me lunch break in work, I'd half an hour, I'd be running out to Ballyfermot for gear, you know.

Why there was no link-up with counselling and support for her as an addict, when she had been admitted to hospital, is not clear.

For this interviewee, the impact of her drug use, combined with the stress of street-selling, led her to give up and return to her mother and, for the sake of her children, seek treatment:

I came home, decided that I had to give me child a life, like, me ma already has me other son, you know. So I went into ____ and they got me help in here.

Motivation to give up heroin is influenced by very immediate events and this is why there is a need for rapid accessibility to available programmes:

But I was only waiting six weeks, like, and I went down there, done the interviews and all the different things you do. But the six weeks I was waiting on ____, I started using [injecting] because I can remember it was the worst time in me life, and I was glad I was after making that step, the weight off your shoulder when you find out everybody knows, like, they know what's happening, they know why you're going round in bits, and they know why you want to get off, like. So I started using in the six weeks.

Thus waiting lists which ultimately represent the under-resourcing of the drug issue create impediments, can reduce motivation and may bring about new complications:

And like it took us, it took me nearly four months I'd say, before I got treatment. I mean I'd go out and score. I had to end up giving ____ [name of daughter] to me mother, 'cause I couldn't bring her to the places I was going or what we had to do.

I think they should make the courses longer, or else, or like, speed up the waiting lists, 'cause I was waiting to get into ____ for I don't know how long, it was a long time anyhow. I can't think the exact time, but it was about three or four months and like what are you meant to do for that three or four months. When you join your clinic, they say to you like, you have to have a dirty urine with heroin in it, 'cause if you don't have it, they say, 'You're grand, you don't need anything. Next please.' So you have to stay on the heroin for an extra four months and then, like, four months beforehand you made up your mind to come off it and then they say you have to wait for four months. As you go along then four months, you're saying to yourself, why should I come off it? I have to do it everyday for months, so I might as well do it all the time.

The mental stress of dealing with the facts of one's addiction can be at least as difficult as the physical stress of coming off it and then attempting to stay off:

A mental addiction, it leaves you with an awful lot of that. 'Why did I do it?' You know, like, 'What made me get into it?' And also, like it's great while you're doing it, but it's when you come away from it, and you see what you've actually done to yourself, and what you've done with your life. Family, friends, children, the whole lot. It can leave a really long-term effect on you. And if you have to deal with it on your own, sometimes you never really come out of it. You never really pull yourself back together again.

In practice, because there is such a strong pattern of abstinence followed by relapse, users in our interviews reported using numbers of different programmes at different points as well as self-detoxing.

Well, I'm after getting treatment now about five or six times, and all the other times me ma was like, doing most of the work, but this time I'm after getting it, I'm doing this and I'm doing that. This time, like, I'm really determined to get off it.

One interviewee, having been accepted on a maintenance programme found herself in conflict with one of the service providers and left to self-detox:

Then I got onto a phy course, and it helped in a way but it didn't really work for me 'cause I didn't get on with the person that was running it. The person thinks that they owned you, because they're over, they run this project, right. So I told them to stuff their phy, I didn't want it. And I went through the sickness, and I'm still going through it. And this is me third week now. I slipped once or twice, but I'm drinking me sleep tea, and taking me herbal remedies and me detox tea, so it seems to be working for me, anyway. I just want to stay off it now, 'cause it's a nightmare.

The success or failure of a particular programme is again very context-bound for the user and perceptions of staff attitudes and philosophies behind drug treatment play a huge role in helping to sustain or undermine motivation:

There's just this attitude from professionals you know. You get treated like scum when you're using, you really do. No matter where you go, no matter what door you knock on. Oh you're on drugs, you're a scumbag and that's it. ... they go on this power trip because they do have helpless people coming in to them, who do have to go through them to get what they want.

The clinic system which arises as a result of having to process many hundreds of clients in a week, and testing their urine to fulfil programme criteria, comes to dominate the lives of users, who must also be vigilant about other forms of intoxicants, including alcohol:

Well, you've to give a urine in front of them, twice a week, and if there's, you know, some people can't even have a social drink and you're cut five mis, you're this and you're that, or thrown on the night programme. You know and you'd be worried, saying if I take this, or painkillers even, that you know, would show up as opiates, you can't even take that. It's just ridiculous. It's just the whole system. I mean, your whole day is taken up, sitting in Trinity Court, waiting for a sup of Phy.

Interactions with clinics were described as demeaning because of this policing:

Having to go to the toilet and making sure that em, can you take this, if you've a cold, you know what I mean, has it got this or that in it.

The entry requirements for various different programmes also created problems and indirectly contributed to limiting treatment options. People who felt they needed tranquillisers to help them were ineligible for some programmes on offer:

Or they want to take the valium to settle them down. Some people might need to, you know, are highly strung and might need to take one or two. Whereas if they're on the day programme, I find they end up

abusing them, say, the twice a week they can take them. And then they're getting caught with it on them. A lot of people are thrown onto the night train, not for heroin abuse, for the tablets.

You give so many [dirty urines] and you know, say you give five, then you give another one, they say right you can have the night programme which is 20 mls of Methadone or 50 mls of brown phy and em, basically you can do what you want on it. You can use on it, you can take tablets, you can drink, do what you want, and like you're nearly a year waiting before you're taken back onto the day programme

3.11 METHADONE AND STABILISATION

There is great controversy about methadone, not least because of its addictive potential. Pearson (1987:169-170) points out that the professional controversies about methadone maintenance have validity: replacing one drug for another and thus sending mixed messages to the user, complicating further the local economy of heroin. But methadone may also offer a breathing space, removing people from the daily stress of robbing and thieving, from daily contact with the drugs scene, and enabling them to get their heads back together, while the physical craving is damped down. So there is also a problem of financing a range of policies and programmes which fit the individual rather than the other way round.

The problems people experience in trying to reduce methadone suggest that it has to be seen as only one part of a wider range of treatment options:

It's much worse 'cause like, when you're coming off something and they're giving you a substitute for it, the substitute has to be stronger, and the phy is stronger than the heroin. But like, you're only getting that in certain doses, and they know when to cut you down, and when not to cut you down. If you're feeling anything you go up and say it to them and you hope for the best.

Physeptone, whatever people say about it, a lot of people say good things about it, but I hate Physeptone because I think it just, it's a worse addiction. The pain, like you're withdrawing from Physeptone, the pain is, I wouldn't say it's as intense, but it's kind of more constant. And it lasts for a lot longer, doesn't it? You know, withdrawal from heroin, you know, if you got good heroin, would take maybe ten days, two weeks, wouldn't it? But from Physeptone, you're not right for a couple of months, I'd say.

3.12 FINDING THE RIGHT PROGRAMME

Some people do feel they get to the right programme over time but it is more trial and error than standardised protocols might suggest:

Q. How long have you been off heroin?

I: Just a little over a year, a year and three months. I had a few, two slips, but it wasn't like a slip, say, one today and then one tomorrow, I forgot about it, it was say, once every six months I had a slip. So, I'm trying when the year and six months comes up not to have a slip. 'Cause this time, like any other time, it's been me doctor, and like, I have got strung out on phy over me doctor not giving me enough and I was telling her from the start, I was saying, 'This isn't doing me.' She really didn't know anything about it and she was saying, 'Well, that's all I can give you over [because of] your age.' That's the way, some doctors go by your age, but like, you could be fourteen and using more than a thirty year old. Age is nothing. And I used to have to buy phy and I was taking 150,170 mls a day. I got strung out on that and I had to go back on the gear to get off that and then I had to just get off the gear

again. I done it with a low amount of phy, and then I got accepted on to the clinic and that's working out for me now.

You get an interview with the nurse down there and then you've to see the counsellor down there, [Name], like they're really nice they are. Then the Tuesday after that, I started down there. I started off on 40 mis of phy, it was grand like. They won't give you more than fifty... About the start of May I started down there. You get urines twice a week down there, I haven't given one dirty urine, I haven't touched gear since I started down there. Like, I really wanted to get off it. I don't think I hang around with any of the friends I used to hang around with.

Where I am now is like I'm on the maintenance now, 20 mis of the methadone per day. Like and I'm actually trying to start a community [scheme].. where I am, you know, so I'm involved with ___ you know, that way. But it was (name of agency) that did actually give me the final pull, like with their therapeutic methods,.. you know, right across the board. Whereas there was none of that in [name of agency] which I had tried. And I tried several detoxes on me own.

3.13 TREATMENT NEEDS

Interviewees were very clear about what services require expansion in order to successfully help people off heroin. Far more resources are necessary to create longer detox programmes, 'not just eighteen days'; many more beds for residential detox programmes, more counselling, and more aftercare. Special residential facilities for those with children is an issue which very badly needs attention. Two interviewees reported problems with this aspect of treatment, one turning down a residential place because she was unable to find someone to take care of her daughter. Respite houses for whatever stage of recovery people have reached are also necessary; they give a break and help people deal with the problems of adjusting to a life without their former friends and acquaintances who were part of a circle of users.

Accounts from those who have failed on previous detox attempts but have begun to feel more in control because they have counselling serve to emphasise the critical importance of best quality provision of counselling:

Yeah, 'cause before I wasn't getting counselling, but now I'm getting counselling sessions every week and they're really doing well for me. Like, most people don't get counselling sessions. And like, if you do get a counselling session, like, they can only see you, say once every two weeks or once a month, but with ___, they're willing to see you every week if you're willing to turn up. I probably missed a session once or twice but there was a good reason for it. Or else, if I'm late, I still come and just say it to the counsellor, who really works for you, the counsellor "You talk to your counsellor what's on your mind, and at the start she doesn't know me from Adam, but as it goes on she gets to know you, and she'll know, or he'll know, if you're feeling down, or there's something on your mind. They're able to tell, and you can just talk to them about worrying saying, "Ah, if this was me ma, she'd be crying at this stage, and you wouldn't be able to finish it.' But with counsellors, they're just able to keep us together.

There also needs to be considerably greater coordination of the various treatment protocols which vary widely from one setting to another. This includes the prison setting:

And the detox only lasts two weeks as well in ____ and that's like, if you're on methadone for a long time, like eight years say, and you're on a maintenance and you go into prison, and they expect you to

come off it in two weeks. And then you've got people in there that have got their syringes and they get gear brought in and they've got HIV and all so, I mean you're sitting there and you're dying sick, and you're offered this. You can't say no.

There are challenges to current and future planning in the drugs services in what the interviewees say about the limitations of treating heroin only as a physical addiction:

So this is where, when they say, okay, detox, great, detox, but what happens after the detox? People's lives are still the same. They're probably even worse, because they've got all this guilt as well, that they've gathered as they've gone along. So their lives were shit before they started using drugs, they've stopped using, their lives are even worse.

And then aftercare as well for people when they've come out of their residential programme, because you know, you've got to fit back in then, you've been living how many years this way of life, so it's gradually getting yourself back into some kind of norm.

Leaving heroin behind will also mean leaving a set of friends who use behind:

If I want to be totally off, and stay off, I just have to, you have to just find a new group of friends, or go out on your own. You can't be off the gear and be still with your friends that are smoking and still selling, 'cause you're always going to be around it and the temptation's going to be there, someone's always going to be sitting there, having a smoke, if you're in someone's house this stuff goes on you know.

Above all, there needs to be much more thinking put into the development of the long-term prospects for recovering addicts, including adequate work training programmes. What this interviewee is arguing is that there must be routes out of the no-hope inner city scenario that made a heroin sub-culture such an attractive option in the first place.

I think the most important thing that people need to get off drugs is help, support, counselling. Something to do. Being active. You know, as everybody knows, a drug user, the major thing that they shouldn't have is time to themselves. I mean it's like giving them a gun. Giving them time, giving them nothing to do. Plus having no money, 'cause you're stuck in the poverty rut again. You know, if you have ten pounds, you can go out, if you're really down, you can go out and you can score. It'll take away the pain for a couple of hours. It'll just block everything out, whereas if you have a tenner, you can't really do anything else. And that's how an awful lot of people get into drugs, because it's a cheap way of blocking out the shit life that you have to begin with, which unemployment creates. And sometimes where you're living, how your situation, what's going on in your life, everything combined can actually bring you to drugs.

3.14 PREVENTION

Coming out of their own experiences, interviewees wanted to discuss the issue of prevention. The magnitude of the current problem is such that they argued young people would be dealing for years to come with the problems set by a drug culture. Those who already had children stressed the importance of talking honestly to their children about the impact of drugs:

I've two children and to me, I just always try to warn them against drugs. And touch wood, they have come out okay, you know. But I mean it took me an awful lot of my time to just keep talking to them, telling them, not saying like you can't do this and you can't do that, but this is what's going to happen to you if you use this and this is the effects of this, that and the other. You know, I had to tell them about everything, what hash does to you, what speed, coke, heroin, and what you had to do to support your habit. How it's going to affect you, how it's going to be with you, you know it never really leaves, it never leaves you. So that was my way of dealing with it.

Parents and schools had a huge role to play. But they were opposed to talks from ‘experts’ like the Gardai:

Like, they let the police go in and do it, and the police have never been on drugs in their life, they’re only going by hearsay.

Some recovering users were involved in education projects in the schools and with groups of young people and their approach was not to lecture but to stimulate discussion of how and why drugs happen and then to stress the personal agency young people can exercise:

We’ll show the slide show and get them to talk really, and a lot of them will say, yeah, there’s problems around here. So we’ll try and say, “Well, what can you do about it?” And put it back onto them. Because I think there’s also a problem of people being too assisted, you know, where all the power has been taken away from them, and people are running their lives for them, saying right, you’re going to do this, you’re going to piss in a bottle at ten o’clock on Monday morning, you know, or you won’t get this. Punishment. It’s treating people like children. They’re not children. They’re people. And so we try and put it back on them, and say, well, you know, ‘Okay guys, do something about it. If you see something is going on, what can you do?’” And we try to go around all the possibilities of what they could do for themselves, instead of relying on other people. Making them aware of the power that they do have.

Giving them lists of drugs, educating them on what the effects of them are, and let them, hopefully, that they will make up their own mind and use their own common sense. You know, like because showing somebody dying like to the virus or like an OD on rat poison or, yeah, it might work, it might work for some people, it might not work, actually it might be a kind of, ‘well that’s a challenge’.

They were too aware that there was no ‘miracle cure’ but that there would have to be answers from many quarters, including direct action from the government to better life prospects for inner city kids:

A better lifestyle, that’d be the great, that would be the alternative, if they didn’t have to live in dire situations.

‘Cause we’ve got to offer something else to kids. You know, if they can’t have painkillers, what can we offer them instead, that will make them happy?

I mean the drug related crime, I mean, Mountjoy is what, full, seventy per cent of the people are in for drug related crimes. It costs forty-six grand to keep one person in prison. It costs twenty thousand to rehabilitate. So you’ve got two people for the price of one. But there’s not [enough] services.

The possibility of legalising heroin and prescribing it on a restricted basis for long-term users was discussed as another strand of action which could prove of vital importance:

We were saying that the ideal thing would be to prescribe pure heroin. Control it, not give it to everybody, but control it. And people want to do that, okay, let them have their clean stuff. At least there would be no drug related crimes, we’d be taking the power back from the drug barons, the government would have the power. And at least they’d know what was going on. And there wouldn’t be any, the prisons wouldn’t be full anymore. There’d be less prostitution.

But if it’s legalised, it’s going to make it all the harder for them. I think it’ll make it harder for them to start. The reason I say it’ll be harder, is because they’re only starting. I mean what doctor is going to give someone, a fifteen, sixteen year old heroin. And if it’s legalised, it’s going to be a lot harder to go and buy it on the streets, because the government would have taken control, or whatever. So I think it would be harder actually, it’d stop it, young people, you know, the next generation.

The deep regret many expressed for the ill-effects of the lifestyle which had caught them up was expressed by one recovering user:

I just feel sorry for anybody I see that's still on it, and I say, 'How long is it going to take them to realise the truth about it, that it is fucking their family up, they're going nowhere with it, like.' Not many people realise that, I'm just glad I did [realise that], you know what I mean?

3.15 SUMMARY OF DATA FINDINGS FROM GROUP INTERVIEWS.

Sixteen people, contacted through three of the agencies which had participated in the prevalence survey, were interviewed for this phase of the research. They were all in treatment when interviewed and had been daily users of heroin. The interviews and the accompanying quantitative questionnaires indicated that initial involvement with heroin was part of a context where young people had already engaged in extensive experimentation with intoxicants, in some instances an impressive range of different substances. The involvement of young people in heroin appeared to be fuelled by a volatile combination of a ready availability of the drug and a changing and expansive sub-culture which rates being 'stoned' or 'wrecked' high in importance. Young people were building a social life around heroin use in the context of a bleak socio-economic outlook for inner city communities. Many were deliberately seeking an alternative lifestyle. Two people only reported turning to heroin after difficult personal and family problems had beset them. All interviewees had slipped into regular use, either smoking or injecting the drug over a period of weeks and months after their introduction to the drug. Again, availability played a huge part in their being able to access the drug without difficulty. Of the 12 users who did not inject on their first engagement, ten went on to inject. Two people whose first contact was via smoking, were still smoking only when they came into treatment.

Two people continued to work in the early stages of their addiction; one using wages to fund purchases of the drug. The remaining interviewees had engaged in various forms of theft, fraud, and dealing in the drug themselves to support their habit. One person had engaged in prostitution in order to fund purchases of heroin.

All had lower rather than higher educational qualifications. The earliest school-leaving age was 13, the latest 17. None had a Leaving Certificate. Several continued to attend school in the early stages of their heroin use. Reasons people entered treatment differed. Some interviewees felt unable to carry on the stress of their daily lives in trying to fund and find heroin. Some felt confronted by the impact that way of life was having on their immediate family. Coming off heroin while hard was not as hard as staying off heroin. A pattern of relapse was the common experience. It was also a common experience to undertake a number of treatment programmes many of which proved unsatisfactory. At the time of interview, most were stable on a methadone maintenance programme or free of all drug dependence.

They pinpointed a huge need for an expansion in treatment services: intensive counselling, a much-needed expansion of residential programmes and the length and quality of detox programmes; aftercare programmes including work and retraining programmes, respite houses, and special residential facilities for those with children to be able to undergo detox regimes were cited as priorities.

Priorities in prevention strategies were to respond to the social and economic crisis of the inner city, to honestly educate school children about drug use while encouraging a model

of personal responsibility, and the restricted legalisation and prescription of heroin for long-term users in order to take the crime out of the inner city.

4 CASE STUDIES OF TWO USERS

4.1 INTRODUCTION

In this section, the main themes and issues laid out in the previous chapter are explored in the context of two extended case study interviews with recovering addicts. These individuals were contacted through community networks and participated only in this part of the research, not the group interviews. The extended interview is an established part of qualitative research and is considered one of its most powerful tools of analysis because it offers a view of how an individual lays out her/his mental universe and how daily experiences are fitted into a frame of reference about the external world (McGracken, 1988). Each of the two interviewees was interviewed on her/his own after telephone conversations and brief preliminary meetings. The interviews were conducted in an informal setting which the interviewee chose. Categories of analysis or themes drawn from the group interviews formed the basis of the interview schedule.

The interviewees were one woman and one man, both now in their mid-twenties, who have lived in the north inner city and played out their addiction to heroin in that setting. Thus among the other factors which brought them to the decision to use heroin on a regular basis, easy availability was key.

4.2 CASE STUDY 1: EMILY

Emily is a twenty-six year old, originally from the inner city area, who has almost completed what she hopes will finally prove a successful regime of treatment for her heroin addiction. Having had very stormy relations with her family, she currently enjoys a much more stable and supportive relationship with both her mother and her father.

Her family, two siblings and her parents, in her analysis, resembled a lot of inner city families when she was growing up, 'like hard times, not enough money, unemployment and trouble at home.'

Emily's profile as a drug user challenges many of the stereotypes about drug users. She defined herself as a troubled and sensitive child who, as the eldest, took on a lot of responsibility for the family which was beset by many problems. Emily had good relationships throughout her schooling with teachers, one teacher in particular, maintaining contact with her and encouraging her straight through to her Leaving Certificate year, during which the teacher paid for a course of extramural lectures for Emily in Trinity College. She was Head Prefect and unlike interviewees in the previous chapter completed her Leaving Certificate at sixteen years of age. She worked abroad as an au pair for some seven months. Later, after her return to Dublin, she did a number of courses, including a City and Guilds Youth Leadership. However, this was a contradictory picture. Always suffering from poor self-esteem, she was outwardly accomplished in her adolescent and early adult years. She also had considerable awareness of counselling and therapeutic approaches for addictive behaviour and had even worked as a volunteer with women who

were HIV+. Despite these perspectives and experiences which she encountered, she played an active part in a youth culture where dancing and intoxicant drug use were strong features, with alcohol running a poor second to illegal drug intoxicants. She also engaged in petty theft.

In the middle of her sixth year, Emily began to take amphetamines to slim. She had developed an eating disorder by the time she was thirteen. She got tablets from friends and described herself as feeling “ugly”, ‘horrible’, ‘dirty’. She also began to experiment with other drugs, including acid and Ecstasy. During this time, she had contact with support groups for addictive behaviour in her adolescence, both alcoholism and eating disorders.

So I was sixteen then, when I was still in school, I started messing with slimming tablets. But everything was just taking a head. For years I'd been kind of, everything is grand, everything is okay and putting up this facade to the world and building up all these defences, you know. But at sixteen then I just felt them all come tumbling down, I just couldn't cope. I felt suicidal and depressed all the time. I stuck it out anyway 'til I did me Leaving Cert. But after that, everything just went dramatically downhill.

I was getting them off friends and that. Me doctor knew me case history and wouldn't give me them. He said I'd probably take the lot together, which he was probably right. But I got them elsewhere. A few people I knew were taking them, you know and they were saying they were trying to lose weight and they were good, and they gave you loads of energy and you could use them going out dancing, and stuff like that. And I loved dancing, but so I started trying them. I used to go out dancing a lot then, onto ecstasy and acid and speed, you know, and cocaine and stuff like that. It was just kind of em, I kind of seen it at the time as counteracting two problems that I would have had. One making me feel good and the other one making me feel good about me body. So kind of to kill two birds with the one stone, you know.

Well, I didn't drink until I was over eighteen. I always said, 'I don't want to be an alcoholic.. Do you know that way, but when I was around sixteen anyway, the thing with the eating disorder, so kind of therapy has played an integrated part of, nearly throughout me whole life anyway. Maybe that's where I got the bit of awareness from. But I remember going to Overeaters Anonymous, you know, 'cause I was using a lot of laxatives and stuff like that as well.

Some of me friends would have been (using ecstasy). But I remember before ecstasy I tried acid and all that, and I was afraid initially, 'cause I had this big thing about being in control, not wanting to be out of control. So slowly but surely I was testing the waters, testing myself and eventually I kind of thought, 'I can handle this.' Do you know what I mean? And I progressed then from acid on to ecstasy. I loved ecstasy because I wasn't, when I did eventually drink, I did drink a lot. But em, I didn't like being drunk, I felt out of control, being drunk, whereas with drugs, I felt more in control. It probably seems absurd, you know, but that's the way it was. You know, and took ecstasy then for a while and dance drugs. I loved going out partying and stuff like that, you know.

She first experienced heroin when she was nineteen. She immediately enjoyed the drug.

Then when I was about nineteen I started dabbling with heroin, like, after being at a big rave one night and went back to me friend's house, and I'd never smoked a cigarette even up to then I'd been taking dance drugs and drinking. And they were smoking heroin, and ecstasy has you so high, for something to bring you down then. And I loved it, kind of when I tried heroin it was real, 'This is it now, this is what I've been missing. This is heaven sent.' That's the way I felt. You know what I mean, I just kind of felt at peace, it kind of, that emptiness or whatever was in there, that gnawing feeling, that haunted feeling, was kind of gone. It was kind of still, maybe for the first time ever in me life. So it was kind of, it felt like a dream come true. You know?

Because she had worked with women who were HIV+, she was aware of the dangers of intravenous heroin use, and was cautious about using needles at first.

I was smoking. And then over the years I kind of dabbled, like with needles and that, but I was never really into them, because I had worked at one time, I was a Women's Support Worker with women with the virus. So it was kind of, and me rationale as well, kept me out there using longer. 'Well, I'm not that bad.' Bit like a superior attitude type thing, you know, denial. Do you know what I mean?

She describes a feeling of invincibility and superiority, thinking that she would never be termed a 'junkie'.

Do you know? 'Well, I don't look like them.' And, 'What people don't know, they can't say about me,' and it was all another facade, the facade just continued in a different form, you know.

The social relationships of the regular heroin user are very rapidly reorganised around users and supplies and this leads to splits in how one lives one's life. At this time, Emily's friends comprised people who were, like her, experimenting with drugs, and another group who was not aware of her drug taking habits.

Well, the friends, it was like I was two people. I had a lot of friends who were straight, so to speak, and weren't into that, and I had friends who were. And one crowd didn't know about the other crowd. So it was kind of, you know, jumping from one to the other. JeckyI and Hyde. You know that way, so the people who I thought would have something to say, I didn't let them know. You know, and even the people, the people who were using that I was with, I felt they might have something to say about being with straight people, so I didn't let them know. Do you know what I mean, playing a game. Well, at the time I considered it like the best of both worlds. But it wasn't, I was only tearing myself apart. You know what I mean? So I suppose I could have went either way at that stage. But this drug, and what it did for me, was what I felt I had always been looking for. So there was no way I had any intentions of letting it go, and yet, in the back of me head I kind of thought, in me conscience as well, you know, a real kind of, 'I can handle this. I'm not that, I won't be like other people. I won't be like them. I'll be all right, I'm bright, I'm intelligent. I'll hold it together. I held it together growing up. I'll hold it together now.' Do you know what I mean? That's addiction speaking for you, but at the time I just thought it was me. This is what I feel, you know.

Her early experiences of taking heroin were very enjoyable. Emily smoked the drug for about a year before trying skin pops.

Initially it was like em, a bit like a tea party type thing, with a few friends after a dance or whatever, you know, and I suppose a sense of belonging, and a sense of, 'Yeah, I fit in here. What we're doing is making us feel good. We're not doing anyone else any harm.' And it went on like that for a while, do you know what I mean, a year. "Cause I was more, still quite a lot into dance drugs. But then eventually after that, it was kind of every man for himself. I stopped going dancing and started getting me own heroin, still kind of seeing friends every now and then, I mean, did that with them, if I could get something off them. Or maybe if I wanted to please them, I could give them something. But eventually it got to the stage, I gave nothing to nobody. A year later I was still smoking. But I had, soon after it then I had a few skin pops, what they call it when you don't mainline. But em, I was just curious to be honest. But I didn't like it because it gave you a sense of not being as in control, as the smoking gave me. I've this big thing, had and still kind of have, about control, do you know what I mean? And even with being strung out, I kind of felt, looking back on it now, I felt in control with me life being out of control. Do you know what I mean. Because I was doing things like the smoking, had jobs, like different jobs on and off, and doing courses, the facade still continued.

I got into a relationship then. After a few months the relationship ended but I was devastated. I was about twenty at this stage and em, I still kind of thought I could handle it but then, soon as the

relationship ended it was real, probably the first time in me life, maybe through the drugs as well, I let meself get close to somebody. And me worst fear came through, being rejected and hurt. So I just started really getting into the heroin then and not giving a care in the world, not caring, do you know what I mean?

And then that's when I knew what it was like to be strung out, because then when I, everyday that I've kind of like manic, 'I want it, I want it.' You know and then going without it was kind of, me mind was obsessed with it. And that's when I started feeling desperate. Desperate until I got the drug, and even then when I got the drug, it was real, 'Oh God, this is going to wear off me, I'm still going to need more.' So the vicious circle had kind of got into full swing. I mainlined on and off, not a lot.

Emily continued to work during this stage of her addiction which was marked by the common pattern of abstinence and relapse. She had self-detoxed "hundreds" of times and then re-engaged with the drug. In fact, she was able to obtain syringes from her place of employment to aid her in injecting.

I was working in (Name) at the time on an outreach course, you know, I was an outreach worker and that. So I used to be able to get the needles, so it was still secrecy, well nobody knows.

Her first formal effort at treatment came about at her mother's insistence. All these early efforts failed.

But I had been clean. But I went back using. I'd been clean, about twenty, no about twenty one I was, maybe twenty two, I started going. Me mother copped on then that I was using drugs and she wanted me to go to _____. And I started going to em, I was working in (Name) at the time, as a Women's Outreach Worker. And so I went to ___ to see the counsellor a few times. I didn't want to go, it was a two year thing, and they had said, I had heard, they break you down before they build you up. And that was my worst nightmare. I was after spending years building up these defences, there was no way there was anyone getting their hands on them, do you know what I mean. So me job got me in touch with _____. So I went to, they had a Residential in Swords at the time. I went there then. And that was only for a month, five weeks I stayed there. Then I left, and em, I remained clean for six months. I got into the _____ then on the medical card. I was only out of the _____ a week or two, and I was back using, 'cause they had focused, went back into me past and stuff like that.

Hundreds of occasions, I couldn't even count how many. I remember in the beginning when em, I was saying to me mother and father, when me father did find out that I was off it and stuff like that, they'd say, 'Well stay in for a week and show us,' And I'd stay in. And I'd go through withdrawal and I'd be up the wall. But loads of times then I'd be buying Phy and trying to detox meself and you know, going away for weekends, telling them I'm going away on a retreat. I'd go away on me own. I knew a priest, and I used to be able to go down the house, to this big retreat house. Bring loads of tablets I might have got off me doctor and try and detox meself. Sure I'd be only back on the train and I'd be using. You know, I kept doing things like that, going away all the time and not wanting to let anybody know. I had this huge thing, some people are different, some people don't care.

One of her siblings was also using heroin and family relations, both sibling and parental were seriously fractured as a result of the stress of these addictive patterns. She was thrown out of her parental home and went to stay with friends.

One time I ran off with a load of money out of the house. I had been street trading as well. I did loads of jobs, you know, and ran off with all the money, booked meself into a Bed and Breakfast in ___ and stayed there for nearly a week. I ended up in the ___ Psychiatric Ward after that.

A crisis pregnancy challenged her to try and detox yet again. But when the pregnancy ended in miscarriage, the trauma resulted in her turning to heroin again.

And then I got, I was a couple of months back using and then I got pregnant. So I was after trying to come off it meself, and I did for three weeks, but I went back on it, and then I discovered that I was pregnant. And I was advised not to go into withdrawal or detox, could cause a miscarriage. So I went em, I took their word. Eventually I had to let me fella know anyway and I said I'd go into _____ to do a detox so I'd be drug-free when I had the baby and stuff like that. But anyway, just before Christmas I was losing the baby. I was four months pregnant. And I just went off the head altogether, you know, having like a bit of a breakdown. And I didn't want to go to treatment, I didn't want to live, to be honest with you. I just kind of thought like, 'cause all me life I could justify and rationalise, I could say, 'Well I'm hurting, I know me ma and da is upset, but really I'm hurting only me. I'm taking the drugs and putting them into my body.' But the thoughts then of affecting another life.

In the wake of this event, formal treatment carried new weight. Emily took on a rigorous in-patient detox and a residential programme.

I didn't want to go anywhere. I just didn't want to live. I just wanted to be able to get away from it. I was losing the head and fighting with me boyfriend, and being physically abusive to him. I was just in so much anger with meself, and hurt and pain, you know, but, eventually with a little push anyway I went to _____. I was probably, like I've had bad detoxes, physically and emotionally and all stuff like that. But it was probably the most, the worst detox emotionally for me and mentally, that I've ever had. I thought I was really losing it. I have this fear about going insane anyway, do you know what I mean, I thought, well this is it now. But I just kept talking, I did their heads in up there. I just kept talking, talking, talking. I talked me way through a breakdown, 'cause I couldn't afford to let meself slide, I knew, it's now or never, I'm going to go off the head here.

I kind of thought em, if I had have been clean and all that. And then, I suppose in the last few months I've kind of got a bit of a handle on it, but I still, I suppose I have a couple of regrets about me past, but I've accepted them. I can't go back and change it. But I'm still trying to get a handle on this one. Like wishful thinking, it was kind of em, I kind of seen it as maybe the one opportunity in me life to show that I was worthwhile. I would have been due to have it around now, so the last week and that has been like emotionally draining, do you know what I mean.

I had loads of rock bottoms. But I think this time, me rock bottom sat on me. You know I say that jokingly, but the miscarriage kind of topped it. I was going off me head, I felt I was losing my mind. You know and I think em, if nothing good came out of the miscarriage, that did. It was real, now if I think of drugs I think of the consequences, what I have lost. Not only the miscarriage but it was probably the thing that was most striking out of everything that I have lost.

See I had all the awareness. I had all the therapy. But it was all up here. And at that stage I was even all therapied out, 'cause it was all up here, none of it was going down. Do you know what I mean? In fact I would have probably used a lot more because of the awareness that I had got, because I was using it against myself. Do you know what I mean? So I needed more, I felt I needed more drugs to kind of, to get away from it, do you know what I mean?

She will be having aftercare support for some time.

I'm not cured. You know, but this time it's different in the sense that I'm more realistic. See usually in the times I've got clean, I put meself under an awful lot of pressure. It's extremes, its all or nothing. I'm either going to be brilliant, or I'm going to be hopeless. One or the other, you know. And it was kind of like em, the goals I have now are more realistic. Whereas before, 'I want this and I want it now.' Like instant gratification. I immersed meself in NA [Narcotics Anonymous], I've been around NA on and off the last three or four years. I'd immersed meself in that. Have it up to here then, get so fed up, throw it all away, do nothing, and go back using. Extremes, you know what I mean? But this time I'm looking to get a balance on it. Me recovery is going to be on-going, but kind of, with a support group and a couple of meetings.

Emily has chosen a total abstinence model herself. She feels that this time she has a good foundation to remain clean, because she has finally been able to ‘internalise’ and make sense of what she learned. The importance of a supportive atmosphere based on friendship in addition to successful and ongoing counselling in returning the addict to a sense of herself is especially striking in Emily’s account. She has experienced in the past confrontational forms of therapy which, for her, proved disastrous. Her extensive experiences underline the fact that no single treatment model or approach to addiction holds the answers for every person.

Instead of thinking all the things and going over all the things in my head that I knew, I had to believe them. And for once in my life I believe some of it, and getting to believe more as the days go on. And I believe, I believe I deserve a life. I said all this over the last few years, but I didn’t fucking believe it.

When I went to ____ this time, from the outset I said, listen, I don’t want therapy thrown at me. I have enough therapy to last me a lifetime, to keep me together if I use it. What I wanted, what I really went to ____ for, was friendship and support. And that’s what I found I got...That’s what I wanted. I had a bit of awareness, all I needed to do was a safe environment to internalise that. But the friendship and support is what has kept me going.

She feels that the nature of her drug addiction has made it difficult to retain her old user-based friendships and that she requires a new circle of friends.

I think even at this stage it would be important for me to have a set of friends who weren’t addicts as well instead of it being like therapy, recovery non stop. You need to live life as well, do you know what I mean. I think that’s what’s different this time.

At the time of interview, Emily had only one week remaining in treatment and planned to obtain her own accommodation, rather than moving back in with her partner. She is optimistic about her future.

4.3 CASE STUDY 2: BILLY

Billy has been in recovery and clean of all drug use for two years. He is twenty seven years old. His family background was that of low-paid unskilled work. His father worked as a roundsman delivering bread; his older sister also worked.

His is the classic case of the young boy who although bright and doing well in primary school became attracted to an alternative culture and as part of that pattern, had extensive early experimentation with intoxicants, including alcohol.

I started off sniffing glue, when I was in primary school, that’s where I started. What happened me was I was hanging around with someone who was older than meself, right, he was two years older than me, and he got his summer holidays a couple of weeks before me, or a month or whatever, ‘cause he was in secondary and I was in fifth class, right. And he said to me, and it’s gas when I think of it, he said, ‘I’m going to be sniffing glue, right, until you get your holidays.’ ‘Cause he’d no-one to hang around with. And I thought it was perfectly normal. And I says, ‘Ah, yeah, right, when I get me holidays you can stop.’ So, I got me holidays and I tried it meself, and that’s when I started sniffing glue. I was about eleven years of age. Straight away I loved it. I got caught the first few months I was sniffing it. Me parents. I was so out of control, I just went in with glue all over me, over me head. I hadn’t got a clue what was going on.

I had a year or two between that and picking up alcohol. And I picked up alcohol first and me next encounter with drugs after that summer was I got drunk one Halloween. I was only a young fella, very young and very bleeding drunk, I robbed spirits out of me house and I drank them and I was twisted. I

got caught again. I was brutal at it, I was. I went home and I tried to keep a straight face, but I just couldn't. I was caught, rapid.

I didn't really like it [alcohol]. I liked the buzz. I liked it to a certain point, but I went over the top, and I started vomiting and all that buzz, and I was in bits I was. I went overboard, you know what I mean? But I did, I did like it, when I think of it. I remember thinking it was good crack and that. I don't think I drank regularly after that again, until I met someone maybe a year later. I drank a bit, now and again. And I was sniffing gas as well, now, at this stage. And then I met someone that was into drinking and buying drink. And I don't know where I got the money from at all, I probably robbed it out of the house on me sister. That's what I did do, in fact. Me sister used to work in some job and she used to have money. And I used to rob it and she'd never even know. And I used to rob the change, me da used to work in ___ and he used to have a float as well, and I used to rob twopences and pennies out of that.

After that, when I met me friends, I drank regularly, at this stage, smoking hash, sniffing gas, going into school drunk. That type of carry-on. I was a very disturbed child, I mean, I really was, you know. I didn't realise it, but when I look back, you know the way they say adolescence and all, when you're fifteen or something like that? I went through a very bad one, but I didn't even know what was going on, when I think about it.

I was very good in school. But maybe if there was thirty-five or forty in the class I wouldn't [bother]. I mean very immature, very cheeky and looking for attention at times, and then very introverted at other times and really unbalanced, like. Really unbalanced, like, fucking, at times I wouldn't say a word; at other times I'd assault the teachers.

He always felt ill at ease with his family and although his parents discovered his substance abuse at an early point and sought help for him, with teachers and other professionals, this did not interrupt his pattern of use.

I was got in touch with psychologists, or psychiatrists and that, at times, as a young fella and that really annoyed me, you know, made me even worse, 'cause I didn't think there was anything wrong. And lid just get up and lid just walk out, or open the window and climb out. And they wouldn't try to stop me. I just didn't play ball at all. I wasn't into it.

And, even though he stayed in school until his Intermediate Certificate, his central focus was on his out of school activities while in school he remained extremely disruptive. He was 'smoking hash, drinking, fighting and robbing.' Expelled from his first secondary school, after efforts on the part of his teachers to offer support (one teacher coming to his home), he enrolled in a different school to repeat his Inter Cert but was still unable to make sense of the demand for disciplined work.

I was in hospital doing me Inter Cert, through strife and trouble. I ended up getting bashed up, and I was in hospital doing me Inter Cert. I had a pretty wild life at that stage. I tell you where I was at, I was quite intelligent at school, right, and I knew you had to wait twenty minutes or something, before you could walk out of a classroom, doing the exams. So, I'd be writing for twenty minutes and I'd know much, much more. And the second that twenty minutes would come I'd just get up and walk out. Like, I just didn't understand it, the penny just didn't drop home with me at all. So every twenty minutes of the exams, I just walked out. And I done a bit in hospital, a bit on crutches and a bit in the school. So, I decided to go to a different school. I was actually told not to come back; I was going to do a fourth year or something, but they told me not to come back, and I went to a different school to do me Inter again. And I tried, I really, really tried the discipline and everything. That was one of the first times in me life I really tried to improve me behaviour and tried to listen to people and take on board.

The excitement and the 'buzz' of intoxicants continued to attract him and petty theft funded his purchases. He first got involved with heroin through selling it to raise funds for

other types of opiates which he had learned to snort. Drinking alcohol on the streets opened up the opportunity for him to get hold of tablets, both to sell and use, and over time, this introduced him to opiate use.

With the alcohol I met wino-type characters, 'cause I used to drink on the streets, I didn't drink in pubs, and some of them were into tablets, and you'd buy them a bottle of wine, and they'd give you a couple of cards, Roche 30s or something. Lethal things. I was only a young fella and I used to take them on Friday night and I wouldn't wake up till Sunday, Roche 30, Rohypnol, Dalmane and all that. They're lethal, they are. You'd get a card on Friday night and there'd be ten of them in it and you'd say, 'I'm going to take two or three of them.' And I'd start coming to on Sunday. You know, me head would be gone, and I'd start coming to, and people would be saying, 'Do you remember this, we done that and do you remember that?' It was mental. Sometimes I'd wake up with a charge sheet in me pocket, or money that I was after robbing on someone. To this day, I wouldn't have a clue what happened.

Billy's actual introduction to heroin came after he was eighteen and after he had lived in England for a year, trying and not succeeding in getting a different way of life together, and meeting people who were using heroin. He tried it at that point but it was only after his return to Dublin, when its availability on the streets penetrated his personal network that he began to use along with his other friends.

I went through the stage of all things like geegees and speed and acid and all that crap. Geegees, DFs, Naps, I was on phy before I ever took heroin. I took all them. I had, funny enough, when I look back, I had this thing against heroin, I didn't want to take it. And I actually started off on it with me friends. My story is, I started selling heroin before I took it. I was greedy, and I was trying to make money out of it. It's a long road, I'd a long road, before I went on to heroin, I mean, I was destroyed a long time before I ever took heroin. I suppose the opiates really wrecked me, snorting and swallowing, I had a big thing against needles back then, too, I didn't want to take needles, I just wasn't into it. And I stayed off needles for a long time, you know what I mean? Then I was selling, and then I started having a few bob. I started having money and I started getting drugs in from somewhere else and all that buzz, and making a few quid, and then I remember one day, and I just says, 'Fuck it, I'll try it and see what it's like.'

I had friends, I'd lived in England at that stage for a year, trying to get me act together again, but it wasn't happening, you know what I mean? And I met people over there that was into smack and could get it, and I just tried it. Smoked a bit of it, and I suppose I was slowly got into it. There was a big gang of us, all, most of my friends were taking it already and there was maybe fifteen of us taking it altogether, and it was like a sociable drug. It was funny, we were using drugs together for six or seven years at this stage and we had a certain place to use them. And it just sort of came in, and at the start it was all, 'Oh, I'm not into heroin, I'm not going to take it.' But then, I just took it.

As with Emily, the drug initially gave him pleasure. It was also the centre of an extensive sub-culture.

It just became like any other drug, and it pulled people together at the start, and everybody started selling it and started trying to, just to support their habit. And if people were sick, you got, 'Oh, there you go, you can sort me out after.' It was all camaraderie, it was just the thing to do. Nobody worked.

It was actually a good time for a while, you know what I mean? I did have a good time for a while. Because looking back in retrospect, it's much easier to see that I used to get meself into trouble with a certain drug, and then I'd go on to something, probably stronger, and stronger, so I never had to give up anything. I just went on to something stronger and stronger and stronger, and that's just the way it progressed for me until I was on to heroin. And I was all right for a while, yeah, when you got your money. And I was robbing at this stage, and I had tasted a bit of prison and things like that. And everybody was on smack, everyone that I knew was on heroin.

It's just if you like it, you do it. It's as simple as that. There's nothing more or nothing less about it. Just if you enjoy it, you just do it, that's the way it was for me. I never thought, I did, I had a resistance to it, looking back, but once I started, I just didn't care. My whole attitude to life was, 'Fuck it, you could be dead tomorrow.' And I just didn't care, I really didn't care, about anything.

Billy's description of his daily routine indicates not only the way an addict's day is structured by the hunt for funds and then for the drug itself but how it becomes challenging and exciting.

I was dealing a good bit of the time. I was always busy, except at the end, I was just sitting in the house. It's a way of life, taking heroin, really. Like, think of the excitement of walking down the road, right, and you're ready for a bit of crime or whatever, and you could get two thousand pound, just like that. Do you know what I mean? And you never know what's in here, or around the corner, or whatever. Now, most of the time you don't be thinking like that, but that's it, you could get a couple of thousand pound, or you could get a tenner. And just the excitement in it. Though, it's not really like that, either. But that's the reality of it, you could, because if you're taking risks you never know what's around the corner.

I was more into selling drugs than into crime, but when I done crime I didn't do petty crime, I planned meticulously, I thought I was a commando at times. I reduced the risk of being caught as much as I could, and then I just went and done it.

I was in prison as a young fella. I was in Patrick's and Shanganagh and all that. But I wasn't in prison since, and me last time I got charged was over ten years ago. So I've made it through ninety per cent of me criminal activity and ninety per cent of me drug use without going to prison. But I was a very paranoid person as well, really paranoid, and I was really careful and me head was destroyed. Sometimes I used to think it would be a lot easier if I just done what I had to do and didn't take precautions, because then I could handle the drugs. Say if somebody wanted drugs here, and just say I didn't care, I could have it. I used to see people that could make loads of money. They'd have it in their house, and if such-and-such wanted drugs, they'd just get it and bring it to him. While I'd have to get in contact with such-and-such who had it in his house, get in contact with such-and-such to get it, pick it up, and drop it to your man, you know what I mean? And I was no big drug dealer, either, I was just very careful. Also, like I have to say, like, I got to the level of getting lumps of money off me ma and spending me Labour on drugs, and it wasn't all glamorous. I was scraping the bottom of the barrel. Like, I got, like me poor mother, you know what I mean, I used to get lumps of money off her, and lumps of money off everyone, and, 'Sure, it's only this, and it's only that', I used to think.

Despite the excitement he describes, Billy made numerous efforts to extricate himself. The same pattern, as with Emily, of different treatment regimes and detoxes was part of Billy's life for almost five years.

I done four or five detoxes in ____ over the years, and I bought Phyl on the streets for years, and eventually I got detox in different treatment centres myself. That's how I got clean. I done ____, and I went back using. I done ____, and then I done ____ again. That's how it worked for me.

He voluntarily told his mother about his addiction.

One of the worst days I ever remember, I remember going down and telling me mother, I don't know what I was looking for, but I says, 'Ma, I'm injecting heroin.' I don't know what I was at, at all, and she didn't say anything. I gave her a big hug. I was shattered, I was destroyed, do you know what I mean? I think I was looking for some type of help. It was a cry for help. And she says, 'Well you're going to have to get yourself together,' or something, can't remember. She didn't make much of a scene, anyway, whatever happened.

Although Billy did not come to a specific life crisis like a suicide attempt, he finally found the pressure and the pain of a heroin lifestyle too much of a burden. His move into injecting cocaine and heroin, the so-called speedball, frightened even him.

I used cocaine, I was into injecting cocaine, and that's serious. It's mental, it is, it's fucking lethal, you use hundreds and hundreds of pounds a day. It destroys your head, it wrecks your nervous system, it turns you into a paranoid bleeding schizophrenic. You go in and you hear voices, you lock the bleeding doors behind you, jam yourself into your house and just take it. You could use, at least with heroin you only take a certain amount and then you're out. With coke, the more you take, right, you can be injecting a bit of heroin, or coke and heroin together, but you'd be injecting the coke and twenty minutes later you'd need more, you'd need it more after taking it than you did before you took it. It's mental. It's worse than crack, 'cause I was smoking crack in London and all, and I smoked it over here, but for me it was worse than bleeding crack, it was lethal. They call it a speedball, when you inject heroin and coke, and it's bad, but coke on its own is even worse, because the heroin brings you down a bit and coke brings you up. But just with that, you can't even act normal, you couldn't act normal, you couldn't pretend to be all right when you take it, you're just mad, you're mental. And after it, when you come down off it, you're so violent, you'll actually kill people dead, you know what I mean, it's lethal. That's what done me, I could have made it on heroin for a long while more, probably, getting me bits and pieces, and getting me twenty and thirty and forty pound. But the coke, if I used one bit now, I'd be gone, like. I remember, if I had a thousand pound there, it'd be all gone. You'd be just gone, you'd stay awake for two days and you'd wake up hating yourself, ah, Jesus, it's horrible. That's what really done me in the end.

I wanted to die. That was it. Pain. That was it, I wanted to lessen the pain. There was no magic formula. I wanted to, the other times I wanted to stop as well, as much, but I didn't take the action. I didn't completely surrender, you know what I mean. This time I was just in so much pain, I was going to kill meself, actually. I heard about NA (Narcotics Anonymous) and that, and I went to it. Ninety meetings in ninety days. I said to meself, 'Well, I'll give meself ninety days. Three months is nothing. I'm on drugs a long time. Three months is nothing. And if nothing changes then I'll bleeding kill meself.' That's the way they left me.

Unlike Emily, therapy and counselling had figured little in his previous attempts nor in his final attempt. A residential detox with a reducing level of methadone, an aftercare programme, plus the structured programme of Narcotics Anonymous seemed finally to make sense to him and he feels he now has a purposeful life.

Four weeks in ____ got me off drugs and that was it. NA every day, every day. NA saved my life. If NA stopped today, I'd be back using drugs tomorrow. Within a week, I'd give meself, if I stopped going to NA meetings, right, I'd give meself a month at the most, and all the mad thinking would come in and I'd forget. See, NA is just people talking about their experience. It's people coming off the streets that's one day clean, and doesn't want to use drugs. And if I stopped going to NA, I'd forget that. I come in to everyday contact with that, and I remember it and I remember it, and me life is so good, I don't want to go back. And I could forget that if I stopped going. And not only that, there's people longer clean, people need me, but I need other people that's longer clean, and I see what their life is like, and it's just getting better and better and better. I have a purpose in me life today, I want to stay clean. And I believe there's so many opportunities going to come my way in life, and I feel ready and able to take them. And I feel ready to deal with the pain and the shit that life throws at you sometimes.

I suppose I look back and say it's the way me family brought me up. I'm a very sensitive individual, I am, and little things can upset me. And I used to blame everyone, and I really believed it was their fault and I used to be into meself, I'd be up in me bedroom, crying, and hating the fucking world and all. You know, just hating, I hated people, it's gas the turnaround that you can get in a twelve-step

programme, 'cause I hated people, I mean I was a seriously angry person, I'd go as far as to say, even among the drug fraternity I was a very angry person, you know what I mean? I stood out.

Even though Billy is living in an inner city flat now, he has had to break with his former set of acquaintances:

'Cause you're bound to be tempted sometime. No, I'm all right with it, I'm all right with it. I'm happy in my recovery today. I don't hang around with people banging up heroin, or smoking joints. If I see them on the street, I see them on the street, but I don't go in and have cups of tea with them.

Billy is critical of the lack of fit between services and users' needs and of staff attitudes and programmes which do not respond to where users find themselves.

I've had terrible bad experiences down there in ____, where I've been desperate, been so desperate, right? There's a certain time that comes up with a drug addict, maybe once every three or four months, or six months: one day where they just want to get off drugs. They want to get off them and they can see it all for what it is, and you try and try and try. Getting off heroin, right, buying phy, trying to bring yourself down off it, this is one of my experiences. I was down on a small amount and I went down to __ to say, 'Look, I need to get it [physeptone]' This is when there wasn't big mad queues as well. And they says, 'You'll have to give urines.' 'Yeah, fair enough,' I says, 'but I'm on the phy now.' They says, 'Ah, no no, you can't, you have to go back for a week, give us six or seven urines.'

He argues that there is an urgent need for detoxes to be longer than they are. He argues that the lack of resources to keep needle exchanges open longer is shortsighted, because injecting users cannot wait for the limited opening hours.

I used to go into a ritual, right, I'd break up me needles, me gizmos, me works, the whole lot and I'd throw them out, right? And I'd say, 'I'm not fucking using drugs tomorrow.' I always wanted to give up drugs. I'd say, 'I'm not using drugs tomorrow.' And I'd wake up in the morning and I wouldn't have no needles or nothing. And I'd get drugs and then I'd share a needle. But if I could the [needle exchange], if I knew I could get one like that, I'd go over and get one over there. But if I couldn't, even if it was opening at two o'clock in the afternoon and it was eleven o'clock there was no way you're gonna wait. Even if it was one o'clock. You might, if it's half one. It's all right to spread the HIV virus before two o'clock in the day, you know what I mean, it's mental, really. I know they're trying to help and they are doing a great job, but there's room for improvement. Big time.

He is also critical about the policy of widespread long-term methadone maintenance being put in place without an expansion of resources to enable people to become entirely drug free from methadone.

One more point I'll have to make: methadone was never meant for maintenance; methadone is for detoxing people and they shouldn't be on maintenance, it destroys them, takes their insides out and it's worse to come off than heroin, I know that meself, it just destroys people.

Heroin is short and sharp and after three or four days you're peaking and then you're getting better. But phy is a horrible drug to come off. You're talking two or three weeks, every day. And you get one day and you think you're all right, and it's back worse the next day, it's mental.⁹

The socio-economic context of unemployment to poorly paid unskilled work, was an important factor for Billy in his drift into a drug sub-culture. Although Billy's father was employed, it was low wage labour and the lack of skilled, well-paid work did have an

9 This same point about the problem of methadone maintenance is also made by the interviewees in the group profiles.

impact on his own way of life. He never worked and at 27 is now trying to redress that by sitting for his Leaving Certificate.

My da worked and I believed that if you worked you never had nothing anyway, 'cause he always worked, and he never had nothing, so I made a conscious decision that I wasn't going to work, and I didn't work. If he would have had a nice car, and all that, from working I probably would have wanted to work, maybe, but I believed that you don't get nothing from working, and I didn't work. I worked in London, you know, a couple of years ago, and I worked since I got clean, but I never worked in me active addiction meself. But there you go.

But he can now see the wider ramifications of how heroin use has happened.

It's a social problem, isn't it, heroin? When you narrow it down. It's so much more than stopping one person taking heroin. It's all about unemployment, job opportunities and living circumstances. It's a lot bigger than any one person, you know what I mean? It's a problem every country in the world has it. I know they're trying to tackle it in a certain way, and there has to be some type of solutions to ease it and help it. But the chances are, if you're growing up in Sean MacDermott Street, right, the chances, if you're any way adventurous, you're going to become a heroin addict. That's just the way it is, or Dolphin's Barn, you know what I mean? And there's nothing to channel your energies. People think heroin addicts are stupid and it's just not true, there's so many clever people out there that could have been this and could have been that, and it just doesn't happen. It's the adventurous people and the people that would make it in life, is the ones that end up taking heroin, 'cause there's nothing to bleeding do and they're broke and spin out of control 'cause there's nothing to bleeding channel your energy and focus on.

I'm a student now going back to school, and I'm unemployed, and me rent allowance ain't very much, and I'd rather live in a nicer area. Twenty-seven, I'm only a young fella, starting out in life.

4.4 SUMMARY OF POINTS FROM THE CASE STUDIES

These extended biographies of heroin use permit us to see two young people who made deliberate choices about that use. Retrospectively, they define themselves as sensitive children. One took responsibility for her family's problems of poverty and unemployment and the resulting family tensions. One was simply angry at the life which was confronting him. Both were bright at school. Both felt isolated before they entered into drug use. Emily had received professional attention from psychologists while still at school and help from support networks. She was familiar with problems of addiction and therapeutic approaches before she took heroin. Billy had been confronted by his parents about his early drug-related incidents involving solvents and had professional attention from psychologists and psychiatrists about his behaviour, as well as efforts from his teachers. These personal reflections however could be relevant details for many adolescents and almost all adolescents would see themselves as sensitive and isolated at some point in their transition years to young adulthood.

The clues to Emily's and Billy's careers as heroin users lie therefore not so much in personal vulnerability as the way young people can become attracted to a different mode of expression or lifestyle which appears to offer positive answers to the issues of their personal identity. At a critical transition point, Emily was attracted to a dance culture, where heroin figured as part of the scene in coming down from Ecstasy, and Billy entered a street culture where intoxicants of all types circulated freely. Both strands of heroin use offered a way of life which was exciting, pleasurable, and which had an easy camaraderie - in the early stages.

However, in the context of the inner city, this way of life is made possible because of a market for heroin which is operating extensively in communities which are already under siege. Both these young people came from working-class families whose social and economic standing was marginalised, where unemployment or very low status, low paid work were the only options. So their points of identity with a heroin lifestyle also say something about what they are rejecting. Billy states explicitly his rejection of the route his father chose of low paid work. With no reward other than existing, “why bother?”, was his response as an adolescent. In Emily’s case, the pleasure of heroin was an antidote to the impact on her personal development of her family life, a life which had been marred by the tensions and conflicts that are part of living with poverty in Dublin’s inner city.

These biographies also offer telling observations about treatment. These two young people (and the sixteen interviewees who participated in the group interviews) had the experience of multiple attempts to break their addiction. In these two case studies, many failed efforts were finally transformed and both are now entirely clean. But both indicate that their disengagement from heroin is an ongoing challenge for them. Emily and Billy, as well as the group interviewees, spoke about the attitudes of staff on drug treatment programmes, where they frequently felt subjected to condemning and judgmental attitudes and protocols.

What their experiences tell us is that treating heroin addiction successfully is extremely difficult. No one model or regime suffices for all individuals. There is a formidable challenge for agencies working in this field to offer a range of treatments that are relevant, that help to re-build personal responsibility and decision-making, but that do not take further from the heroin user’s already deeply diminished sense of self-respect. The very core of the problem of treatment for heroin addiction is that it is not an affliction amenable to a simple medical solution. It is a physical, personal, social and economic affliction which requires cogent and adequately resourced actions on all those fronts, including long-term aftercare. But these actions have to be locally based. This is where young people are still trying to come to terms with their lives as addicts. This is where, for them, the problem began.

5 RESEARCH AND POLICY PERSPECTIVES ON THE HEROIN PROBLEM

5.1 HEROIN - ITS HISTORY AND CURRENT ECONOMIC IMPACT

Heroin has had a lengthy, if varied history in the West. It became a major trading commodity from 1773 onwards, first through the British East India Company which spread the mass use of the drug from India to China as part of its expanding Asian trade routes. The drug was part of a huge commercial trade which also dealt in the stimulants of coffee, tea and cacao (McCoy, 1991). Heroin entered Western annals through bottled medicinal remedies containing opium, such as laudanum, which were freely and cheaply available from pharmacists and grocers and which became a staple aspect of self-medication - and dependence - for urban and rural working-class communities (Berridge and Edwards, 1981). This dependence was referred to as a 'habit' rather than addiction. Recent research has also indicated that there were strongly class-related differences in the responses to opium use. Middle class usage was linked to 'mental distress' whereas its use as a stimulant amongst working class communities was linked to very poor social conditions (Harding, 1988). The term 'addiction' arose in a period of increasing concern about widespread use when it was reasoned that people did not choose the drug so much as they became captive to what were thought to be its' overwhelming pharmacological properties (ibid.). Between 1850 and the beginning of the twentieth century, sales of these opium-based medicines increased seven times (McCoy, 1991:8).

In medical treatment, heroin was used by 1860 in combination with the hypodermic syringe as an anaesthetic. Mass production of synthesised heroin, in the form of diacetylmorphine was begun by the giant pharmaceutical company Bayer, in Germany in 1897 and it was they who coined the trade name of 'heroin' (McCoy, 1991). By 1909, there were international moves to regulate and reduce opium production world-wide, as awareness about its addictive properties grew, and from a level of over 41,000 tons of legally produced heroin in 1906, tonnage was reduced to 7,600 by 1934. A total global legal ban on sales of narcotics was set in place in 1961 by the UN (ibid.). So, roughly speaking, heroin operated as a legal commodity for some 150 years and has operated as a restricted or illegal commodity for the past seven decades. In the earlier period of legal heroin trade, it was one commodity in a range of stimulants that circulated in international trade - coffee, tea, tobacco and spirits, all of which became essential to enabling us to adapt to the rhythms of industrial society. The targeting of heroin as a restricted or illegal drug has occurred during a period when the capacity to produce psychoactive drugs has mushroomed beyond our collective imagination. This growth has accustomed the individual to think of altering his or her mental state with stimulants and psychoactive drugs as an ordinary everyday choice, whether it is tobacco, cups of coffee, ecstasy, heroin or Prozac. What is important to note here is the frame of reference which western society has sanctioned as a whole about stimulants. Within that frame of reference, we have then tried to say that some substances are legal and relatively freely available (tobacco and alcohol), some are restricted (prescription drugs) and some are illegal (cannabis, cocaine, ecstasy, heroin etc.)

In this latter period, heroin has taken on a very different profile in terms of its use. There have been periodic upswings or 'epidemics' in its use in the United States. In Britain, its use had stabilised by the 1960s with the official number of heroin addicts around 3,000. The 1970s saw a gradual increase in those numbers (Pearson, 1987). But it was the years

between 1979 and 1981, that the contemporary problem began to take shape. This was linked to the expanded potential of fields under cultivation in Pakistan, Afghanistan, Burma and Laos and the economics and politics of new and heavily financed routes of distribution. Heroin now makes a significant contribution to the international drugs trade; the latter is now estimated to comprise close to two and a half billion pounds, according to UN agencies. Its huge profit base is argued to have contributed substantially to the corruption in governments at all levels internationally. In a recent open letter to the UN Secretary General prior to a special UN general assembly on drugs, thousands of international signatories argued that the drugs industry “has empowered organised criminals, corrupted governments at all levels, eroded internal security, stimulated violence and distorted economic markets and moral values.” (*Guardian Weekly*, June 14, 1998). This is now an extraordinarily sophisticated network.

Yet despite the sophistication of technologies and travel involved in developing these new routes of distribution and the involvement of hugely powerful players such as illegal cartels (or the American CIA in the early 1970s in Laos and Cambodia), the drug, like the coca leaf before it is made into cocaine, remains a peasant crop, is still raised by subsistence farmers. Moreover, in the West, much of the final distribution appears to be carried out by retail sellers on streets who are equally economically marginalised (see Preble and Casey, 1969, Parker et al, 1985; Pearson, 1987; Grapendaal et al., 1995; Bourgois, 1997).

However, there are differences within this general pattern. It is clear that in the United States and Britain, crack cocaine (especially in the United States) and heroin are drugs which have had a particularly high level of circulation in working-class and marginalised communities (see Parker et al, 1985; Pearson, 1987; Taylor, 1992;

Bourgois, 1997). This stands in contrast with the Dutch experience, for example, where there is a more even dispersal of heroin use amongst social classes, with the most marginalised class accounting for 42 per cent of heroin users (Grapendaal et al, 1995: 43-44). In Britain, Pearson (1987:3) observes that the pattern of distribution of heroin, although strongly associated with areas of serious poverty and unemployment is nonetheless a ‘highly scattered and localised phenomenon’.

The data from the prevalence study and from the users in the group interviews and the extended case studies indicate the extent of a similar pattern in Ireland. Heroin use and the way of life which accompanies heroin appears to have afflicted primarily working-class Dublin communities since the early 1980s (see Dean et al., 1983, 1984). This is not to say that there are not middle-class heroin users. Of course, there are. Indeed it is likely that heroin use can bring them into a category of economic marginalisation so that they too turn to finance their habit through selling, as in the Netherlands (see Grapendaal et al, 1995). But middle class heroin drug use is an area about which very little is known at present in Ireland or indeed elsewhere. Parker et al. (1985) argue that middle-class use, like women’s use of heroin is more likely to remain hidden. Undoubtedly, the patterns and meanings of middle-class use require specific research.

The focus of this current study is the fact that the circulation and economics of the drug in the Irish context have centred heavily on the marginalised locations in the greater Dublin area, with Dublin 1, 7 and 8 taking the worst of the blow. A central hypothesis of this study is that policy approaches to the problems set by heroin use need to be checked against the

experiences of drug users in order to identify where aspects have worked and where there are gaps both in orientation towards the realities of users' lives and in service provision.

The aim in this chapter is two-fold: first, to examine findings from in-depth studies elsewhere which have concentrated on the collection of first-hand accounts of illegal drug use in marginalised areas. This will enable us to test the relevance of our qualitative data findings. We then want to set out how our data findings match the objectives of our evolving drugs policies. The overall objective is to lay a sound basis for the recommendations in the concluding chapter.

5.2 RECENT QUALITATIVE STUDIES ON HEROIN USE

By the mid-1960s, in the United States, heroin use as we have come to know it here in Ireland was already an established sub-culture. A long way removed from the late nineteenth century/early twentieth century stereotypical image of women consuming their bottles of laudanum, discreetly purchased from the local chemist, the stereotypical image of this new wave of heroin users was that they were poor drop-outs from the American way of life, people who were inadequate personalities, rendered passive by their heroin use. Preble and Casey (1969) set out to contest this perspective and their qualitative data indicated the extent to which the regular heroin user works to keep his habit going. These ethnographers were the first to use the term 'career' in relation to the ongoing work of finding money to buy heroin, finding a dealer and consuming the drug, the linked activities which they termed 'taking care of business'. In testing the relevance of this model with data from the Heroin Lifestyle Study, Walters (1985) argues that the daily lives of drug addicts are not so different from those of non-addicts. Like ordinary non-addicts, 80 per cent planned their day when they were first washing their face and dressing in the morning. They did feel differently on waking from people not consuming intoxicants and/or psychoactive drugs. They were reminded of their addiction as soon as they wakened, 'cotton-mouthed' and there was an urgency to attend to the addiction to take the edge off those feelings. The Heroin Lifestyle Study sought to show a user's typical day and collected data from 124 respondents. This data revealed common themes across both geographical locations and age groups in that all committed daily users of heroin spent most of their day in activities related to sourcing and funding their drug intake. But this was accomplished alongside quite ordinary activities which could be part of anyone's life, user or not. Walters quotes the example of one user who fed his bird and gave his ageing mother her medicine before setting off to 'work'.

In our profiles, we have similar examples of young people working, attending school, taking care of young babies and children. It is important to note that a heroin user continues to perform other social roles and tasks unrelated to her/his heroin use.

In order to fund their habit, Walters (1985:35) argues that users develop into being 'patient, flexible and versatile dealers,' who must be ready to take advantage of any opportunity which arises. Of course, it is undeniable that drug addicts do lie, cheat and steal. But they do so to fund their habit. Johnson et al. (1985:55) also argue from their data that the committed regular daily heroin user is far more criminally active than the occasional heroin user.

Criminal activity is one of the crossover points where concerns about heroin addiction as a personal affliction have become bound up with the issue of heroin as a social problem (the other point is public health concerns about the spread of HIV infection). In one of the first attempts to profile the new wave of heroin use in Britain, Parker et al. (1988) observed that

the development of widespread regular heroin use in the Wirral was accompanied by an unprecedented increase in recorded crime. Their interviewees were unambivalent on the connection between the two developments. Only just over a quarter of their sample were involved in crime prior to sustained regular heroin use. Once involved in the later, 87 percent were directly or indirectly involved in illegal activities in order to finance their habit (ibid: 103-4).

Parker et al. argued that their data bore out with remarkable similarities the findings of American studies of heroin use where an uncertain even dangerous lifestyle is intertwined with distribution networks for the drug and crime to finance purchases. Although we did have one user who reported using her wages to fund her habit with no criminal activity involved, she was the exception in a sample which reported multiple illegal ways of trying to support themselves on the drug.

Parker's work is germane to the situation in Dublin because of the similar socio-economic circumstances of the communities in the Wirral he studied. The heroin 'epidemic' in the Wirral of the 1980s was completely without warning or precedent. Highly local heroin user networks were established by the beginning of 1980, and had become by 1984 a widespread social problem, impacting on the lives of marginalised young people from deprived communities. Two key factors stand out from Parker's data in respect of contact and motivation. Users were almost always introduced to heroin by someone known to them as a friend, relative, mate or partner. When asked what had motivated their trying it out, the commonest single response was curiosity (Parker et al., 1988:47-48). Respondents spoke about heroin giving them a different kind of 'hit' compared with other drugs, interesting enough for them to want to experiment further with heroin. Becoming a daily user, moving into injecting use, if they had not injected from the outset, the taking up of a lifestyle which this necessitated are also clear themes in the data. Parker and his colleagues were anxious to observe that there is no single pattern to drug careers, either how they start, carry on or whether or how they end, not least because so much is dependent on personal and social variables, the latter including availability of the drug. They argue that the combination of legal sanctions, prohibitions and illegality are 'as important in the aetiology of a drug career as any primary causes such as personality.' (ibid.:67).

Despite the variability, there were shared themes around issues of getting involved and then coming off and staying off. Almost all their 61 interviewees had made efforts to self-detoxify. Interestingly, Parker refers to this as part of a 'learning process, in which the user first comes to terms with his or her dependency and second, sets about finding the appropriate path to take' (1988:55). Staying off in that mid-1980s period was complicated by the lack of maintenance facilities and by conflicting views on treatment within the medical field, which often meant a user confronted inflexible and unworkable regimes. These factors, as much as personal and social factors impacted on whether or not a user would be successful in overcoming addiction long-term.

Geoff Pearson's ethnographic study of heroin users in the north of England in 1987 focused on these same "new heroin users" who were 'perfectly ordinary young people' from ordinary working-class neighbourhoods (Pearson, 1987). His analysis focuses on the way heroin as a problem begins amongst a network of friends. Thus there is active decision-making amongst friends about first experimenting with heroin and if they choose not to stop, adopting a lifestyle which is centred on heroin and the myriad activities required to keep that way of life going. Familiarity is the key to a successful heroin economy being established at local level. He comments that you must be a familiar face on

the scene. It is from his data that Pearson makes the argument that heroin is a pleasurable experience for many people, pleasurable because it dissolves people's worries. This rationale about heroin should be seen as stemming from an active decision rather than conceptualising people as passive victims of the pharmacological action of the drug.

As one of our interviewees put it, she "felt good" taking heroin whereas alcohol left her feeling out of control: this is a purposeful argument even if it leads in the long run to a position of deep regret, as Pearson points out. He also points out that if we are to understand the nature of people's relationship to the drug we have to listen with greatest care to how they speak about the drug from their early experiences to the complications and grave difficulties they encounter in trying to come off heroin.

As with the other studies reviewed here, there are many similar themes to our own data which emerge, including the critical factor that most heroin users whom Pearson interviewed had already experienced a wide range of other drugs before they tried heroin. There is much debate amongst professional addiction counsellors and medical doctors about whether there is a 'gateway drug' - a drug that once young people experience it makes the 'progression' to heroin easier. What this theory lacks is any sense of social context. It is not one drug or several drugs which function as gate keepers for young people and decide whether or not they will use heroin.

It is the social context of their lives - what they decide they want to do with their friends, what makes up having a good time of an evening, that excitement about getting "wrecked", the curiosity, and of course the availability at local level - the local drugs culture will be shaped by what drugs are on the street market. Our data shares with Pearson's an extensive exploration of how young people are thinking about drugs as part of their social scene. As Pearson argues 'the drug culture into which the novice heroin user moves .. is interested only in getting wrecked every day, day in and day out'(1987: 46).

For Pearson, the lessons from north American ghettos for deprived working class communities in Britain has to do with how a drugs subculture comes to operate in 'the social void of poverty and unemployment' as a way of life that offers a person status and self-esteem.

Bourgois (1997) examines this argument in the context of a Puerto Rican ghetto in East Harlem in New York City which has been torn apart by crack cocaine. He observes that the total retail sales related to crack are easily the most important local economic activity. Despite the self-evident destructive life of those caught up in addiction to crack cocaine, the failure of the mainstream economy to offer any decent way of life to ghetto residents leaves open the possibility that working in the crack trade will provide an alternative occupation which does hold out the hope of status for many individuals. He argues that the phenomenal growth of the drugs subculture is an expression of 'deeper structural dilemmas' (1997:319). Thus although policymakers search for short-term solutions to the drugs problem, there is a desperate necessity to understand that the deepening crisis around substance abuse has taken place because of a polarisation of structural problems that generates "self-destructive behaviour and criminal activity" (ibid.)

He argues that there is a vital necessity to transform the current imbalance between the illegal drugs economy and a legitimate economy which offers at best unskilled work and very low pay. At present, retail sales of illegal narcotic drugs represents the best opportunity people have of obtaining steady work, even if the context of that is dangerous in so many ways. Bourgois's work graphically illustrates these dangers: sellers use

themselves - thus in the best of weeks they make probably only as much -as they would in the very low pay legitimate jobs they have rejected. Moreover, with conflicts between dealers and police activity, so much can go wrong for them. Nevertheless, with nowhere else to go, the illegal drugs economy provides them with an extensive activity “which soaks up energy and ambition that cannot be absorbed elsewhere” (ibid.:321). What these communities need is the legitimate policy efforts, including decriminalisation of drugs, to lift them to a level where they can achieve respect and dignity and a way to carry out their family lives that does not threaten their very existence. He concludes with an argument as relevant to the Irish context as to the American: ‘painful symptoms of inner-city apartheid will continue to produce record numbers of substance abusers, violent criminals, and emotionally disabled and angry youths if nothing is done to reverse rising rates of poverty, class and racial division’(1997:325).

What Pearson (1987: 133-4) refers to as a lifestyle grounded in a ‘rigorous timetable of events’ features strongly in Taylor’s ethnography of women heroin users in Scotland in an area riven with problems of poor housing, poverty and unemployment. She collected data and interviews with injecting heroin users over a 15-month period of participant observation in their daily lives. Taylor argues that in medical, psychological and psychiatric perspectives, women drug users are commonly portrayed as passive individuals who are psychologically or socially inadequate. This passivity, inadequacy and dependency is said to account for their vulnerability to drug use, the introduction to which usually comes through their male partners. Taylor’s data said something quite different. Women were frequently and actively discouraged from drug use by their partners who were using. But male use could make the drug socially acceptable once use had commenced and a minority of women whose boyfriends were retail sellers had ready access to the drug. Introduction to heroin was achieved through an already-known social network of friends and acquaintances. Women reported heroin as giving them a more exciting way of life and for some, expanded both their options and sense of self-confidence.

All the women were polydrug users but their drug of choice was heavily dependent on availability. Heroin, as with other drugs, was tried out of curiosity and because it was available without going outside their social circle. A few women began to use heroin at once, without recourse to other drugs and only came to polydrug use through their heroin habit when heroin was not available and they had to rely on other drugs. The issue of availability, price and available funds also shaped drug use. Hence some women switched from smoking to injecting because the latter was more economical.

Once involved with regular drug use, they pursued an active career, similar to male users, although there were differences between their activities and male activities in respect of funding the drug. Women were more likely to use the ‘softer’ forms of illegal activity, shoplifting rather than housebreaking, for example. Taylor characterises them as hard-working resourceful individuals who organised their day around their drug use but also allowing for other aspects of their lives. For Taylor’s interviewees carried out their careers while working through other stages of their lives as women: some were already single parents; some became pregnant while Taylor was carrying out her research, some were in partnerships. They took for granted the risks they ran with police about their lives as addicts, just as they took for granted the need to fund the drug in any way possible: non-financial means like depending on others’ supplies, prescriptions for users, or renting out their accommodation to pushers were common activities. Dealing to sustain their own habit and prostitution relied on their thorough knowledge of streets and drugs networks. Taylor

argues that the women as user-dealers and as buyer-sellers of stolen goods contributed to the economy of the area. The problem is that poor communities do benefit from the proceeds of the criminal activities of drug users via the informal economy in this way (1993:94; this point is also made by Parker, 1988 and Bourgois, 1997) which inevitably fosters the conditions for continued drug use in the absence of comprehensive state activity to re-create a devastated local economy.

The issue of giving up for the interviewees was often entwined with their work as mothers; either as pregnant women fearful of the impact on their babies of heroin use, or fearful that that their children might be taken into care if they did not successfully stop using. Other reasons for wishing to cease drug use were: weariness with the hassles associated with scoring; concern about their health; concern about unsafe practices associated with poor quality street drugs.

But they were confronted by the same difficulties in coming off and staying off as have been reported elsewhere: inadequate rehabilitation facilities; problems in restructuring their friendship network; loneliness; lack of help with practical problems - like women with young children for example who required special assistance; lack of anything concrete to replace the routine of the drug user's day.

There is one final study with qualitative data which is included here because it does not have an exclusive focus on impoverished working-class communities of Britain and the United States. Thus it may tell us about aspects of heroin use to which policymakers must respond in addition to the mammoth problems set by local communities in economic and social crisis as a result of long-term social exclusion.

Grapendaal et al. (1995) carried out a study in Amsterdam which investigated the criminal activity of 85 Dutch drug users. Just over 40 per cent of these were from a background of long-term family unemployment for either mother or father or both. In the Netherlands, 'soft' drug use has been decriminalised and 'hard' drugs, while illegal, have greater visibility in mainstream society. The policy efforts have concentrated not on solving the drugs problem through achieving a permanent end to drug use, or by carrying out a war on drugs but on helping both individuals and their society cope with the problem. Thus, the Netherlands has put in place an extensive and pragmatic policy of harm reduction where low-threshold facilities and programmes such as methadone, needle exchange, shelter support, meals and guidance counselling give the individual support, while recognising that s/he only can make the decision about how they want to live. This has been viewed as a more realistic policy rather than to try and achieve the probably unattainable goal of permanent abstinence and rehabilitation for all drug users. If a drug user wishes an abstinence programme of treatment it must come as a specific request in order to tap motivation.

Although just over half of the 85 addicts who contributed to the core research had been engaged in crime before taking up a heroin lifestyle, the emphasis in social and criminal policy not to marginalise the drug user appeared to result in a lower crime rate of Dutch addicts compared with British addicts, once regular use was established. The authors argue that the efforts to prevent complete marginalisation also prevent Dutch heroin users retreating to a deviant lifestyle 'where desperate and antisocial behaviour' is a matter of course (Grapendaal, 1995:195). In the context of a social welfare system which is very much better financed than its British equivalent, heroin drug use in the Netherlands still reflects a social background of those who have less exciting life options open to them -

only 14 per cent of this sample came from a parental background where both parents were working in definable middle-class jobs - and the children were presumed to have greater life options as a result of their class placement. Addicts still go through similar career phases in terms of why they first take up the drug - experimentation - and why eventually they become weary of the drug, the periods of abstinence and relapse, the disruption to relationships, the dangers of overdoses etc. After an average career of fifteen to twenty years, they either stabilise with methadone, tablets and alcohol or come clean altogether and resume a mainstream, conventional way of life (ibid. :198). A fundamental finding in the Grapendaal work is that the heroin drug-using population is stabilising, with the average age of users getting older. This is not the case in Britain or Ireland.

The Dutch project suggests that even where the extreme edges of deprivation, ghettoisation and a subcultural deviant lifestyle appear to have been avoided, heroin drug use is still a sought after activity which leads to social exclusion (which Dutch policymakers have attempted to minimise by their treatment policies of harm minimisation). It is an activity taking a terrible toll in Ireland at present: in the first six months of 1997, there were 30 deaths related to illegal drug use coming before the Dublin City Coroner's Court (Irish Times, 6 July, 1998). The issue remains how to tackle the burden illegal drug use currently presents for the most hard-hit communities which already suffer extensive social exclusion in countries like Ireland.

In summary, there are many points of similarity amongst the eight qualitative studies reviewed here and the data obtained in our study in the north inner city:

- Entry to heroin use through a familiar social network;
- Ready availability of the drug to young people in that network;
- Motivations of curiosity, excitement and 'buzz' in initial experimentation;
- When regular use has set in, a lifestyle dominated by the business of heroin;
- Illegal activity to support regular use;
- In British, American, and Irish contexts, hard drug addiction offering an alternative career to young people from marginalised backgrounds;
- Street trade in illegal drugs form an extensive and expanding market in these countries include restricted prescribed drugs;
- Multiple efforts at self treatment and available formal treatment to stay off heroin;
- Staying off heroin critically dependent on appropriate treatment and aftercare facilities including a structured day to replace heroin-linked activities of funding and sourcing the drug;
- Critical need for long-term training and employment for former users which translate to stable permanent work opportunities.

5.3 POLICY RESPONSES IN IRELAND

The value of doing qualitative or ethnographic research on a social problem of importance to the entire community is that policies to respond to that social problem can then be measured against the realities of people's lives in order to judge whether they are being developed in the most effective way possible.

The context of heroin use in Ireland from the 1970s onwards was one where, as Butler (1991) and Murphy (1996) argue, drugs policy was fragmented and unresponsive to the social context of drug use. Government policy was caught up in issues of dealing with supply and control, with developing specialised services for treatment, with the emphasis

on a medical model of rehabilitation. Butler argues that by 1984, when the heroin epidemic had bitten deeply in the inner city and in areas such as Dun Laoghaire, community groups did confront the authorities seeking funds to help with the drugs crisis at local level. This included seeking funding for youth unemployment schemes in areas like Sean MacDermott Street and funding for a local community college. Local people were acutely aware of the importance of attending to long-term problems of education and unemployment if alternatives to the heroin sub-culture were to be created. But mainstream policymakers were not thinking in such terms and these early efforts foundered.

The challenge of HIV infection from the mid-1980s marked a change in government responses about drug use and by the end of the 1980s, a series of harm reduction measures around drug use were part of public health policy. But such policies were about containment of the virus, not about a direct response to the complexities of the problem of heroin use. And, between 1990 and 1996, as the National Report on Treated Drug Misuse indicates, the figures for those presenting for heroin treatment doubled in that time. It was that crisis which provoked direct action by community groups during 1996.

The 1996 Ministerial Task Force on Measures to Reduce the Demand for Drugs marks the first time that the government has taken on the lesson of what Pearson (1987) calls the need to treat the problem locally where it began. The effort has come very late for many communities. The Community Response study of the South Inner City indicated in 1997 that more young people than ever before are using heroin and at a younger age (McCarthy and McCarthy, 1997). The general thrust of the local drugs task forces is to engage parents and local community groups in prevention and education work while pressing for more locally-based treatment facilities, a widening of options for treatment and support, and inclusive well-grounded strategies on training and employment for recovering users.

At the level of the Health Board and the Department of Health, treatment policy continues to focus on programmes to achieve harm minimisation where people are still using heroin; treatment programmes based on methadone to control addiction in the short-term and the objective of achieving a drug-free lifestyle in the long-term; and aftercare and rehabilitation programmes (EHB, 1997).

But our data indicates a mammoth gap between policy aspirations such as those expressed by the local drugs task forces, currently available treatment programmes and how heroin users actually experience treatment programmes, let alone the problem of aftercare and actually establishing a new life and identity. The length and timing of treatment programmes are inadequate as are the types of programmes. Methadone maintenance is all that is realistically on offer for many drug users and it offers them no realistic future if it is not accompanied by extensive support programmes. There is too little counselling, far too little residential space. There is too little official recognition that there is no one form of treatment which will work; there is woefully insufficient attention paid to education and retraining that can provide a long-term meaningful way of life to former users. Far too few programmes match up with the realities of neighbourhoods which have been torn apart by drugs. There is a social context to heroin use and to assisting people to deal with their heroin lifestyle long-term.

Heroin use is a volatile combination of young people, their curiosity and desire to experiment, in local communities which have been cut adrift from the main economy by de-industrialisation and international corporate restructuring. These communities in Dublin suffer the isolation and exclusion of not being part of mainstream political decision-making; of not participating in the new wealth creation and job opportunities of late 1990s Ireland. They endure the impact of drugs dealing on the local economy, suffering too from the worst of crime-generated drugs activity.

The argument has been advanced in the Irish context, echoing an international debate, that drug prohibition is not solving the problem of opiate drug use and is creating many more in its wake of which an uncontrolled profit-driven black market and unregulated quality of opiates available on the black market are perhaps the two most damaging consequences. From this stems the huge costs of containment of the criminal aspect of heroin, to which can be added the staggering costs of imprisoning drug users who are committing crime to support their habit (Murphy, 1996). It is also argued that the Dutch model has not gone far enough in its pragmatic approach to the opiate problem. Maintaining heroin's illegal status means that the same two factors of criminalised activity and marginalisation create insuperable problems in responding to the impact of heroin use for the individual and her/his immediate environment (ibid.).

We may have to continue to live with the activity of opiate drug use in developed societies, whether or not laws are changed. We need expanded modes of response and we need not to lose the value of lessons already learned. The Swiss government spends 60 per cent of its annual budget devoted to dealing with the drugs problem on law enforcement, 13 per cent on treatment programmes and 12 per cent on prevention education (The *Guardian*, 24 June, 1998). This is not a sensible distribution of scarce resources.

Bearing this in mind, and the problems associated with treatment regimes which have aimed for permanent abstinence and failed, the Swiss took up a treatment model which was previously used for a limited period in Liverpool. In 1997, the government was able to announce the results from a three year trial where 800 heroin addicts were maintained on medically controlled legal prescriptions of injectable heroin. This treatment model acknowledged that some people will use heroin regardless of treatment options. The institution of the restricted administration of heroin thus targeted long-term addicts who had failed every other treatment regime. The results of the experiment were very positive. Criminal activity amongst this group of long-term addicts dropped to 10 per cent; many are now in long-term employment; many were able to re-enter treatment and discontinue opiate use altogether. Many participants who had been heavy users of cocaine and sedatives in addition to heroin withdrew from these other substances. The support and care which were an integral part of the programme were also key to helping addicts reach new decisions around their drug-using behaviour (ibid.; Uchtenhagen et al., 1996). In October, 1998, protocols for this experimental programme were confirmed by the Federal Assembly of the Swiss Federation. These stipulate that those eligible for the programme must fulfil the following criteria:

1. Be 18 years of age or over;
2. Have been addicted to heroin for two years or more;
3. Have already tried and failed treatment programmes twice;
4. Have health, psychological or social deficiencies caused by the consumption of drugs.

(*Drug Net Europe*, 1999:7)

5.4 BUILDING POLICY RESPONSES: CONCLUSIONS AND RECOMMENDATIONS

5.4.1 Broad Findings

There are six broad findings from this study which we believe should contribute to the current policy debate on illegal drug use. These aspects must be taken into account if future policies are to become more effective:

1. The decision to use heroin is an active choice taken in a context shaped by several overlapping factors. These factors include the following: young people who increasingly experiment with a range of intoxicant/psychoactive drugs as part of a search for an exciting lifestyle; communities which have been offered no significant educational, social or economic benefits by mainstream Irish society; and an illegal market which makes heroin easily available. On this basis, we conclude that the explanatory models common to much thinking in the area of drugs prevention, of ‘peer pressure’ and ‘gateway drugs’ do not adequately represent how young people become involved with drugs and need to be rethought. When trying to explain why they engage with drugs, a model which speaks about a social network, multiple experimentation with drugs, and ready availability more closely reflects the reality of young people’s lives.

2. Regular heroin users support their habit by dealing in heroin and other drugs. All interviewees reported this phenomenon in the course of their involvement with sustained heroin use. The data also indicates how other proscribed drugs, methadone, and other prescription drugs, circulate as illegal commodities with several different functions: experimentation; as a way to raise money for heroin; as a substitute for heroin; as a means to help self-detox.

The pervasive nature of street dealing by drug users must be taken into account when responding to problems of supply. The failure of prison sentences to deter retail dealers who are users or for users charged with petty crime related to the funding of their habit, has been amply demonstrated in the Irish context. This failure has been compounded by the lack of adequate facilities within prison for drug users. Alternative models, where for example, the user/retail dealer is offered a choice between prosecution/imprisonment and a rigidly adhered to treatment contract with probation, need to be assessed.

Models like the Swiss experiment (see above), where heroin has been prescribed on a legal but extremely restricted basis to long-term addicts to remove them from dealing, also need to be considered as an urgent intervention in order to reduce the numbers of those involved in street dealing. Very serious attention needs to be paid at government level to putting in place a system of controlled, restricted supply and monitored use of heroin for established addicts in order to close down the retail street market for this drug.

3. Heroin users in their efforts to come off and stay off heroin encounter multiple failures before reaching an equilibrium. This failure is connected with the range and type of services currently available. It is vital that there is a system of integration and cooperation between different agencies. There is a pressing need for a sensitive and fully resourced range of services to address users’ needs at all points in their careers. It is important that these services are locally-based and locally-run. There is no predictive model of who will be successful in coming off heroin at which point.

Thus no one treatment model will suffice. But critical to all treatment regimes is the provision of aftercare and long-term daily support programmes.

4. The gender breakdown of those in treatment is almost even. five men to four women for the inner city. These figures challenge the prevalent stereotype of the drug user as being an unemployed young male from the inner city. It is critical for policymakers to accept that women are a significant part of the drug-using population, that they report less frequently for treatment, and that they have special needs. Mixed gender treatment systems may disadvantage them further and attention should be given to developing facilities and programmes which are women-only programmes in order to respond fully to their needs. Special needs relating to women with children urgently require attention. Women drug users do not cease the work of parenting and childcare simply because they are using. Treatment facilities must take this into account. A more open climate for the treatment of women drug users, and creche and specialist facilities for women seeking residential care must be put in place.

5. The large number of heroin users from the prevalence study from Dublin 1 is directly related to how a heroin sub-culture has flourished in an area which has been gutted by economic restructuring. It is critical that the recent work set in place by the Area-Based Partnership Companies, under ADM, to create financial supports and long-term strategic plans for the development of the social economy at local level be sufficiently supported by government. It cannot be stressed strongly enough that if the problem of heroin use is to be brought under control, young people must be offered real alternatives to social welfare and short-term CE schemes; there must be put in place as soon as possible, best-quality training, and long-term employment opportunities at local level.

6. Prevention of heroin use will be achieved by providing a sense of empowerment and self-esteem for young people and their community. Young people in the inner city are completely familiar with the damage done to people in their community by long-term heroin use. They are also completely familiar with a long-term sense of failure in their communities at many levels, beginning with schooling. Conventional health education programmes do not address these issues when discussing drug misuse. Measures must be put in place and sustained to support alternative social and educational programmes which will return a sense of pride to inner city communities.

5.4.2 Specific Recommendations

In targeting these broad objectives, we offer below the following specific recommendations on the basis of our data:

1. The standardisation of mechanisms for multi-enumeration data collection, using explicit identifier categories, on heroin and other drug misuse on an annual basis. This should include street surveys, working through residents' groups, to try and plot with greater consistency the size of the population not in contact with any drugs treatment or front-line agency. The data also underlines the value of carrying out a survey with multiple points of contact in order to try and gain as true a snapshot as possible.
2. Expansion of the range of services available to include a social model of drugs treatment, including such lifeskills aspects as reality therapy, art and relaxation techniques.
3. Treatment agencies should be supported to develop active daily schedules for people in recovery. These schedules must have elements of support, counselling, longer detox programmes and best quality, long-term aftercare programmes.

4. Women-only programmes and support facilities should be designed for women in treatment, including group work and personal development. Women with children have special needs to help sustain them in treatment, including the problem of childcare and this requires further examination. Creche and specialist facilities for women seeking residential care must be put in place.
5. Prison treatment programmes should be upgraded and developed to the same standard as those suggested for agencies and clinics outside of prison.
6. More use should be made of Section 28.2 of the 1977 Misuse of Drugs Act. This includes a provision that allows the Courts to request reports on the medical situation and the vocational, educational and personal circumstances of an individual. On the basis of these reports, the Courts are then able to order, in place of a penalty, that offenders be directed to treatment instead of incarceration. At the same time there is a need for treatment and care programmes for drug users in prison to be incorporated into integrated aftercare services to support people when they have left prison.
7. If Irish government policy continues to follow the approach set out in the Misuse of Drugs Act, 1977 which makes it an offence to supply or distribute 'controlled drugs', it must do so with legal programmes and interventions that realistically respond to the role of the retail illegal street market in sustaining drug use. The medically supervised prescription of pure heroin, on a restricted basis, to long-established addicts who have failed all other treatment programmes and who have long prison records for drug-associated crime should be considered. This would have a positive impact on the problem of drug-related crime.
8. GPs who want to treat heroin users in their communities should be adequately resourced in respect of training and back-up facilities to do so. This will relieve pressure on the agencies, and provide people with a greater variety of treatment options. Women may especially benefit from this arrangement, as many are reluctant to become involved with statutory agencies because of fears of disruption to their families and relationships, including children.
9. Placing a legal obligation on statutory bodies to provide safe, secure playground facilities, and green areas for inner city residents. Well-resourced after school clubs, youth and sports clubs operating from these facilities would have a positive impact on the chances of younger children to develop their lives outside a heroin culture.
10. If prevention of heroin use is to be achieved then peer education programmes that provide a sense of empowerment and self-esteem for young people, that relate to their own knowledge and experience of heroin as a social problem, should be developed and supported.
11. There is a need for consistency in policies and resourcing from the Department of Education and Science in relation to the supply, quality and training of skilled teachers to deal with problems of disadvantaged areas. There is also a need to mainstream the lessons emerging from alternative school projects and increasing the investment in existing specialised intervention projects for young people at risk.
12. As noted above, the drug problem in the North Inner city takes place in an area that has suffered from the cumulative effects of economic marginalisation. Building up local enterprises in inner city areas by long-term investment in job creation and training programmes is vital to enhance young peoples' life chances in the North Inner City.

13. A targeted jobs initiative for long-term drug users should also be introduced. It requires bold social and political initiatives on many different fronts to unravel the problem of heroin use. Reducing the number of people who engage in heroin and responding to those who are already regular users will cost a great deal. Not to respond will cost even more. In the Irish context, because of the social/spatial dimension of heroin use, the integral importance of community-based and locally run efforts cannot be stressed enough.

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